MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-6

CERTIFICATE OF DEATH

08751 4 4 Reg. Diat. No.

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6020 Pinehurst Road
(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3. (a) FULL NAME WALTER G. ALLEN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minnetta B. Allen

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) December 23, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	29	hrs. min.

9. Birthplace Elmira, New York
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name William S. Allen

13. Birthplace New York

MOTHER 14. Maiden name Helen Lyon

15. Birthplace New York

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1946 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St. Balto., Md.

19. 9-30 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 11 1946 to Sept. 27 1946 and that I last saw him alive on September 27th 1946

Immediate cause of death Embolus of left cerebral Artery — DURATION 2 Wks.

Due to Mural Thrombus of left ventricle — Unknown

Due to: Infarction of left ventricle

Due to Arteriosclerosis of left coronary artery anterior descending branch — Unknown

Other conditions Arteriosclerotic aneurysm of abdominal aorta and Cerebral atrophy, arteriosclerotic. — " — "
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLINICAL DIR.

Address VA. FT. HOWARD, MD. Date signed 9-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

08752

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 114 Oak Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Oak Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William W. Balls

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widower

6.(b) Name of husband or wife: late Cordelia L. Balls nee Burkardt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 14, 1876

8. AGE: Years 70 | Months 2 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Retired

FATHER
12. Name: Barnabus Balls
13. Birthplace: England

MOTHER
14. Maiden name: Sandrock
15. Birthplace: Unknown

16. Informant: Walter E. Balls
Address: 114 Oak Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 25/46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: 2930 Frederick Road
18. Funeral director: Harry F. Witzke
Address: 401 Edmondson Ave

19. 9/23/46 (Date rec'd by registrar) 19..... A. W. Redent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22/46. 19..... at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 19 33 to Sept 22 19 46 and that I last saw h[illegible] alive on Sept 22 19 46

Immediate cause of death	DURATION
Terminal Hypostatic Pneumonia	2 days
Due to: General Arteriosclerosis & Myocardial Degeneration	9 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Elliot W. Johnson MD M. D. or other
Address: 3432 Dudley Ave Date signed: 9/23/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161-2

CERTIFICATE OF DEATH

Reg. Dist. No. 08753 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Hrs
Hospital, Institution, or street address where death occurred: Bologna Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME Russell Baby Barger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	✓

6.(b) Name of husband or wife: —

7. Birth date of deceased (mo., day, yr.): 9-16-46

6.(c) If alive, give age: 4 Hrs years

8. AGE:

Years	Months	Days	If less than one day
			4 hrs. min.

9. Birthplace: Lutherville (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Theodore Barger
13. Birthplace: Penna

MOTHER
14. Maiden name: Naomi Cox
15. Birthplace: Lutherville, Md

16. Informant: Mrs Naomi Barger
Address: Bologna Ave Lutherville, Md

17. (Burial, cremation, or removal. Which?) ✓ Date thereof 9-17-46 (month) (day) (year)

Cemetery or crematory: Pleasant Rest
Location: Balto Co

18. Funeral director: Mrs Geo. H. Holland
Address: 1631 Druid Hill Ave Balto, Md

19. 9/17 19 46 (Date rec'd by registrar) Geo. H. Holland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 19 46 at 10 45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 19 46 to Sept 16 19 46 and that I last saw him alive on Sept 16, 46 19

Immediate cause of death	DURATION
Pulmonary Edema	5 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Bennett A. Stoer M. D. or other
Address: Lutherville, Md Date signed 9/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-B)

CERTIFICATE OF DEATH

08754

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 4 mos., 0 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 4 mos., 0 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3909 Ridgewood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Bernard Philip Bayline

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Mildred Bayline
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): November 12, 1897

8. AGE: Years	Months	Days	If less than one day
48	10	2	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and State)
10. Usual occupation: Salesman
11. Industry or business

FATHER
12. Name: Joseph M. Bayline
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Mary Kelly
15. Birthplace: Baltimore, Maryland

16. Informant: Bernard Philip Bayline
Address: 3909 Ridgewood Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1946 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cemetery
Location: 4430 Belair Road, Balto., Md.

18. Funeral director: Krause Funeral Home
Address: 1216 S. Charles St., Balto., Md.

19. 9/14/46 19 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd - 9-17-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1945 to Sept. 14, 1946 and that I last saw h... im... alive on September 14, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Larnygitis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. (M. D. or other)
Address: Mount Wilson, Md. Date signed: 9/14/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 08755 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Balto Co

City or town: Balto Highlands (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Balto Co

City or town: Balto Highlands (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2916 Ohoi Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frank Albert Bell

3.(b) Social Security Number: 212-05-7360

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude Ellen Bell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10/7/1883 ?

8. AGE: Years	Months	Days	If less than one day
62	10	25 ?	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: Gas & Elec Co

FATHER 12. Name: John A Bell

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Ella Kich

MOTHER 15. Birthplace: Md

16. Informant: Gertrede Ellen Bell (Wife)

Address: 2916 Ohio Ave Balto Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/46 (month) (day) (year)

Cemetery or crematory: Loud n Park

Location: Fredrick Rd

18. Funeral director: Edward Foulson

Address: 2359 Wash Blvd Balto Md

19. 9/4/46 (Date rec'd by registrar) 19 ..... A.W. Fredrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2 19 46 at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 46 to Sept 2 19 46

and that I last saw h... alive on Sept 2 19 46

Immediate cause of death	DURATION
Hypertension C.V.D	2 years
Pulmonary - Bronchopneumonia	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Paul Schofield M. D. or other

Address: Mgr Annex Date signed 9/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 10756 X 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Fullerton, Balto. Co
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Fullerton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9009 Ridge Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Miranda Bissell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George F. Bissell
6.(c) If alive, give age: 69 Yrs.

7. Birth date of deceased (mo., day, yr.): Dec. 22nd., 1876

8. AGE: Years	Months	Days	If less than one day
69	8	24	######## min.

9. Birthplace: Baltimore, Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Stevenson Magness
13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: ? Wooden
15. Birthplace: Harford Co., Md.
16. Informant: George F. Bissell
Address: 9009 Ridge Avenue
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/46 (month) (day) (year)
Cemetery or crematory: Hess
Location: 8020 Harford Rd. Balto. Co. Md.
18. Funeral director: George J. Ruth, Inc.
Address: 1735 Harford Avenue
19. 9/17 (Date rec'd by registrar) 19 46 Wm. Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16, 1946, at 9 00 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 44, 1944 to Sept. 16 1946 and that I last saw h.. alive on Sept. 14, 1946

Immediate cause of death	DURATION
Carcinoma of breast	2 yr.
Due to: Generalized metastasis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harold A. Gott, M.D.
M. D. or other
Address: 8100 Harford Rd. Date signed 9/16/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-a)

08757

P

CERTIFICATE OF DEATH

Reg. Dist. No. 4-5

1. PLACE OF DEATH:
County Baltimore
City or town Glen Arm
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Glen Arm Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Glen Arm
(If outside city or town limits, write RURAL and give nearest town)
Street No. Glen Arm Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ann Elizabeth Blakely

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband ~~or wife~~ Clarence Elmer Blakely
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) January 31, 1893

8. AGE: Years	Months	Days	If less than one day
53	7	16	____ hrs. ____ min.

9. Birthplace Loch Raven, Balto. Co., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
FATHER 12. Name John Thomas Finn
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Agnes Hines
15. Birthplace Maryland
16. Informant Mrs. J. M. Mast
Address Glen Arm, Balto. Co., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19 1946 (month) (day) (year)
Cemetery or crematory Mt. Maria Cemetery
Location Towson, Maryland
18. Funeral director John Bussard Sons
Address Towson, Maryland
19. 9/18 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1946, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to Sept 16 1946
and that I last saw h[illegible] alive on Jan 3 1946

Immediate cause of death	DURATION
Carcinoma of right ovary	2 yrs +
Due to	
Due to	
Other conditions Bilat. Carcinomatosis of viscera	1946

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of ovary - all viscera.
Date of op. Jan 4 1946
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. W. Bishop M. D. or other
Address 501 Sharon Date signed 9/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★08758 Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Parkville (If outside city or town limits, write RURAL and give nearest town)
Street No. 2815 Hillcrest (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Isabel Baldwin Boone

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	widowed

6.(b) Name of husband or wife: Charles H. Boone
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 4 - 1849

8. AGE: Years	Months	Days	If less than one day
97	2	12	hrs. min.

9. Birthplace: Baltimore - Md. (Town, county, and state)
10. Usual occupation: Retired Housewife
11. Industry or business:
FATHER 12. Name: James Parsons
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Mary Baldwin
15. Birthplace: Baltimore, Md.
16. Informant: Mrs. Isabel Strickland
Address: 2815 Hillcrest Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept-18/46 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore
18. Funeral director: Wm. Cook
Address: St. Paul & Preston Sts.
19. 9/16 1946 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 1946, at 6.35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1941 to Sept. 16 1946
and that I last saw h[illegible] alive on Sept. 4 1946

Immediate cause of death	DURATION
Chr. myocarditis	6 yrs +
Arteriosclerosis	6 yrs +
Due to: General debility of old age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. M. Bacon M. D. (M. D. or other)
Address: 2810 Taylor Ave. Date signed: 9/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

08759

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Govedale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Govedale
(If outside city or town limits, write RURAL and give nearest town)
Street No. Phila. Rd. & Dalton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Eleanor A. Booth

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John J. Booth

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 7, 1911

8. AGE: Years	Months	Days	If less than one day
35	3	10	.....hrs. .....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name John F. Huber

13. Birthplace New York

MOTHER 14. Maiden name Catherine Stein

15. Birthplace Ger.

16. Informant Mrs. John J. Booth

Address Phila. Rd. & Dalton Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 20 46 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Baltimore

18. Funeral director Philip Herwig Sons

Address 2224 Orleans St.

19. 9-18-1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946, at 4:1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1938 to Sept 17 1946 and that I last saw h.. alive on Sept 17 1946

Immediate cause of death	DURATION
Rheumatic Cardiac vascular renal disease	7
Due to	
Due to	7 Years
Other conditions Coronary Thrombosis	3 Days

(Include pregnancy within 3 months of death)

Major findings of operation .....

.....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Alex L. Sikorsky M. D. or other

Address 2939 Eastern Ave Date signed 9/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2939 Mc Elderry St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (914)

08760

CERTIFICATE OF DEATH

Reg. Diat. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel F. Bosley.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Mary A. Bosley
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 4 - 1867

8. AGE: Years 79 | Months 6 | Days 10 | If less than one day ... hrs. ... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Retired farmer.

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Preston F. Bosley
Address: Glyndon Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17/46 (month) (day) (year)
Cemetery or crematory: Pleasant Glen
Location: Balto Co. Md

18. Funeral director: Edw. Gilston
Address: Hampstead Md

19. Sept - 16 - 1946 (Date rec'd by registrar)
Darry B. Ehline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 19 46, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 14 19 46, to Sept. 14 19 46
and that I last saw him alive on Sept 14 19 46

Immediate cause of death	DURATION
Coronary Occlusion	20 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury None Injured at work?

23. SIGNATURE: D. D. Eagles, M.D. M. D. or other
Address: Reisterstown, Md. Date signed: Sept 15 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-B)

CERTIFICATE OF DEATH

08761 4X

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1905 Cecil Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: CHARLES J. BRADLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-19-1899

8. AGE:

Years	Months	Days	If less than one day
46	11	25	hrs. min.

9. Birthplace: Emporium, Pa. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business:

FATHER

12. Name: James Bradley

13. Birthplace: Unknown

MOTHER

14. Maiden name: May Germond

15. Birthplace: Pennsylvania

16. Informant: Clinical Records, Vets. Adm. Hosp.,

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-18-46 (month) (day) (year)

Cemetery or crematory:

Location: Wesleyville Pa.

18. Funeral director: Odell Funeral Home Inc

Address: 4644 York Road,

19. 9/16/46 (Date rec'd by registrar) Leo Helwig Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1946 at 12:29 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13 1946, to September 14 1946

and that I last saw him alive on September 14 1946

Immediate cause of death	DURATION
HEMORRHAGE FROM ESOPHAGEAL VARIX	1 Day
Due to: Cirrhosis of liver	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Same As Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. M. Cullison Robert M. Cullison R. M. CULLISON, M.D., CLIN. DIR. M. D. or other

Address: VA, Fort Howard, Md. Date signed: 9-15-46

Wesleyville

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

08762

Reg. Diat. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 6012 York Road (If rural, give LOCATION)

2.(a) If veteran, name war SAW

3.(a) FULL NAME (Wells) ROBERT W. BRADLEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6/25/72

8. AGE: Years	Months	Days	If less than one day
74	2	23	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Robert H. Bradley

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Matilda Jones

15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/46 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director Wm. J. Tickner & Sons

Address North & Penn. Aves, Balto., Md.

19. 9-20 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 19 46 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 46, to September 18 19 46 and that I last saw him alive on September 18 19 46

Immediate cause of death	DURATION
Confluent lobular pneumonia	2 Days
Due to	
Due to	
Due to	
Other conditions Arteriosclerotic atrophy of brain & Hypertrophy of prostate (Include pregnancy within 3 months of death)	Unknown "

Major findings of operations .....

Date of op. .....

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address V. A. Ft. Howard, Md. Date signed 9-19-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08763 B

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Baltimore
City or town Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs. 2 mo. 8 days
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 13 years 2 mo 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 307 Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Angela Cecelia Brode

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 2, 1924

8. AGE: Years	Months	Days	If less than one day
21	9	3	..... hrs. ..... min.

9. Birthplace Cumberland Allegany Co., Md.
(Town, county, and state)
10. Usual occupation Inmate, Rosewood State
11. Industry or business Training School

FATHER
12. Name Gerald Brode
13. Birthplace Maryland

MOTHER
14. Maiden name Theresa Schmitz
15. Birthplace Pennsylvania

16. Informant Institutional records; Rosewood
Address State Training School, Owings Mills, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof 9/9/46 (month) (day) (year)
Cemetery or crematory St. Peter's & St. Paul's Cem.
Location Cumberland, Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 9-5 19 46 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 19 46 at 11:55 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 19 44 to September 5 19 46
and that I last saw her alive on September 5 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	22 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE George C. Mudsing M.D.
M. D. or other
Address Owings Mills, Md. Date signed 9/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

08764 P

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1065 Fairmount Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME FRED BROWN

3. (b) Social Security Number 212-14-3089

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Married

6.(b) Name of husband or wife Iola Brown

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) January 20, 1891

8. AGE:

Years	Months	Days	If less than one day
55	8	1	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name George Brown
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden name Violet Delow
15. Birthplace Cambridge, Md.

16. Informant Vets. Adm. Clinical Records
Address Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 25, 1946 (month) (day) (year)

Cemetery or crematory Balto. National Cem.

Location .....

18. Funeral director Mrs Katie R. Williams

Address 322 N. Schroeder St.

19. 9/23/46 (Date rec'd by registrar) 19..... A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 19. 46, at 1:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 19. 46, to September 21 19. 46 and that I last saw h... im ...alive on September 21 19. 46

Immediate cause of death	DURATION
Heart Disease arteriosclerosis,	
cardiac enlargement, myocardial	
DUE TO insufficiency	24 days
	plus
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. M. CULLISON, M.D. CLINICAL DIR. M. D. or other

Address VAH Ft. Howard, Md. Date signed 9-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

45-3-116-775-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08765 30

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County BALTIMORE

City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE

City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 HILTON AVENUE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

~~GRACE WALLACE~~ BURFORD, GRACE WALLACE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	MARRIED

6.(b) Name of husband or wife WILLIAM A BURFORD

~~July 25~~ 6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 25 1870

8. AGE: Years	Months	Days	If less than one day
~~76~~ 76	2	3	hrs. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name WILLIAM E WALLACE

13. Birthplace MARYLAND

MOTHER 14. Maiden name AGNES Gough WALLACE

15. Birthplace MARYLAND

16. Informant WILLIAM A BURFORD

Address 130 HILTON AVE CATONSVILLE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Sept 30 1946 (month) (day) (year)

Cemetery or crematory New Cathedral

Location Balto Md

18. Funeral director Henry W Jenkins Sons Co

Address McCulloh & Richards Sts.

19. 9-28 1946 (Date rec'd by registrar) Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1946, at 1. a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1941, to Sept 28 1946

and that I last saw h[illegible] alive on Sept 12 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J M Collins M.D.
M. D. or other

Address 3361 Frederick Ave Date signed 9/28/46

Dr. James M Collins
3321 Frederick ave

Loane Registrar
Harry W. Miller
10 Magnolia ave
Catonsville

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

08766 P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs., 2 mos., 10 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 35 yrs., 2 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto. Co.

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 834 South Third Street, Canton
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Butkae

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 6, 1870

8. AGE: Years: 76 | Months: 5 | Days: 11 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: ? Butkae
13. Birthplace: Germany

MOTHER
14. Maiden name: ?
15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/46 (month) (day) (year)

Cemetery or crematory: St Matthias

Location: O'Donnell St

18. Funeral director: Blanche P. Hoffman

Address: 1639 Broadway

19. 9/20 (Signature of registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17 1946, at 7:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1911, to September 17 1946 and that I last saw her alive on September 17 1946

Immediate cause of death	DURATION
Terminal pneumonia	2 days
Due to: Chronic myocarditis	indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 9-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 5-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08767

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County —

City or town Cincinnati

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2600 Stanton Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Lewis Eldene Campbell

3.(b) Social Security Number 288-03-0574

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Stella Nichols

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov 5 1876

8. AGE: Years	Months	Days	If less than one day
69	10	—	..... hrs. ..... min.

9. Birthplace Boone County Kentucky (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business —

FATHER

12. Name Walter Campbell

13. Birthplace Ky

MOTHER

14. Maiden name Mary Passon

15. Birthplace Ky

16. Informant Allisby & Rose

Address 1021 Madison Ave. Covington, Kentucky

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 1946 (month) (day) (year)

Cemetery or crematory Burlington Cemetery

Location Burlington Ky

18. Funeral director Wm. Berryman & Sons

Address Reisterstown, Md

19. Sept. 6 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946, at 4:15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-5 1946, to 9-5 1946 and that I last saw h[illegible] alive on Sept 5 1946

Immediate cause of death	DURATION
Fractured skull (Left Frontal)	9 Minutes
Crushed Chest	
Due to Shattered Lumbosacral	
Fractured Division of Left Femur	
Due to Lacerations & Abrasions of Face	
Fractured Left Tibia & Fibula	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-5-46

Where did injury occur? Woodensburg (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Auto accident Injured at work? No

23. SIGNATURE D. D. Caplan, M.D. and Examiner M. D. or other

Address Reisterstown, Maryland Date signed 9-5-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

08768

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs., 9 mos., 24 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 25 yrs., 9 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mary O. Carcand

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1867?

8. AGE:	Years	Months	Days	If less than one day
	79	?	?	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER 12. Name: Thomas Carcand

13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Jones

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 1946 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 9-13- 1946 Harry D. Miller Deputy Registrar
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1 1946, at 11:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 1920, to September 1 1946

and that I last saw her alive on September 1 1946

Immediate cause of death: Acute exacerbation, chronic myocarditis — DURATION: indefinite

Due to: Arteriosclerotic cardiovascular disease — DURATION: "

Due to: Chronic interstitial nephritis — DURATION: "

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.

Address: Catonsville-28, Md. M. D. or other

Date signed: 9-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

08769

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk 22
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, Institution, or street address where death occurred:
2806 Yorkway
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Dundalk - 22
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2806 Yorkway
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME: Bernard Michael Clark

3. (b) Social Security Number: 213-07-5114

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian T. Clark
6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.): August 22, 1897

8. AGE: Years	Months	Days	If less than one day
49	1	0	.....hrs. .....min.

9. Birthplace: Scottdale, Pa.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: John Clark
13. Birthplace: Scottdale, Pa.

MOTHER
14. Maiden name: Martha Shay
15. Birthplace: Pa.

16. Informant: Mrs. Lillian T. Clark
Address: 2806 Yorkway, Dundalk

17. Burial-Removal Date thereof 9/26/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: St. John's Cem.
Location: Scottdale, Pa.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 9/24/46 19..... A. W. Hedrick Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 1946 at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1946 to Sept 22 1946 and that I last saw him alive on Sept 22 1946

Immediate cause of death	DURATION
Coronary Thrombosis	5-6 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....
.....Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury Injured at work?

23. SIGNATURE: J. Howard Burns M. D.
M. D. or other
Address: 54 Dundalk Ave Date signed: Sept 22

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

08770 X

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 641 Pierce Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: GEORGE L. CROSLIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-5-1892

8. AGE:	Years	Months	Days	If less than one day
	54	5	29	hrs. min.

9. Birthplace: Conway, S. C.
(Town, county, and state)

10. Usual occupation: Odd Jobs

11. Industry or business:

FATHER
12. Name: John Croslin
13. Birthplace: North Carolina

MOTHER
14. Maiden name: ? Bulocks
15. Birthplace: South Carolina

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/9/46 (month) (day) (year)

Cemetery [redacted] Balto. national

Location:

18. Funeral director: A. Halstead
Address: 918 Druid Hill Avenue

19. 9-6 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4, 1946, at 1:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29, 1946, to September 4, 1946 and that I last saw him alive on September 4, 1946

Immediate cause of death	DURATION
Lobar, Pneumonia, left lower lobe with empyema	Since 7-27-46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIRECTOR
Address: V.A. Ft. Howard, Md. Date signed: 9-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 307

CERTIFICATE OF DEATH

08771 30
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs. 6 mos. 26 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hosp.
How long in hospital or institution? 9 yrs. 6 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5303 Beaufort Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie Daughton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles Daughton deceased
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 23, 1884

8. AGE: Years	Months	Days	If less than one day
62	3	8	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Practical Nurse
11. Industry or business Private Home
MOTHER FATHER
12. Name John Franklin Myers
13. Birthplace Baltimore, Md
MOTHER
14. Maiden name Mary Jane Williams
15. Birthplace Baltimore, Md.
16. Informant Hospital Records
Address Spring Grove State Hosp.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-3-46 (month) (day) (year)
Cemetery or crematory Lorraine Park
Location Woodlawn, Md.
18. Funeral director G. Howard Strong
Address 3207 W. North Ave.
19. 9-3 19 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 19 46, at 10:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 19 37, to Sept. 1 19 46
and that I last saw h e alive on Sept. 1 19 46

Immediate cause of death	DURATION
Chronic Myocarditis	Indefinite
Due to Generalized Arteriosclerosis	Indef.
Due to	
Other conditions Somatic Loss	Indef.
Prolapsed Uterus	Indef.

(include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Doctor Funk M. D.
M. D. or other
Address Spring Grove State Hosp. Date signed 9-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08772 44

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 334 Days

Hospital, Institution, or street address where death occurred: Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 334 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1520 E. Chase St. (If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: EUGENE DAVIS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married--Sep.

6.(b) Name of husband or wife: Bennie Davis

6.(c) If alive, give age: 2 years

7. Birth date of deceased (mo., day, yr.): 7-10-1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58	2	20		

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER 12. Name: Gus Davis

FATHER 13. Birthplace: South Carolina

MOTHER 14. Maiden name: Katie ?

MOTHER 15. Birthplace: South Carolina

16. Informant: Clinical Records, Vets. Adm. Hosp. Address: Ft. Howard, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 10-3-46 (month) (day) (year)

Cemetery or crematory: Balto. National Cem.

Location: Baltimore, Md.

18. Funeral director: Charles P. Lane

Address: 892 Madison Ave.

19. 10/2 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30, 1946 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20, 1945, to September 30, 1946 and that I last saw him alive on September 30, 1946

Immediate cause of death	DURATION
Metastatic carcinoma lungs & bones	1 Year
Due to: Carcinoma of prostate	2 Years
Due to:	
Other conditions: Synhilitic aortitis	2 Years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D., or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A., Ft. Howard, Md. Date signed: 9-30-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-2)

CERTIFICATE OF DEATH

08773

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto. Co.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Frederick Road
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: John H. Hoffmeyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Hoffmeyer
(If married, widowed, or divorced)
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 7-1872

8. AGE: Years: 74 | Months: 1 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Lottie L. Hoffmeyer
Address: Lenox Manor

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Sept 13 46 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Frederick Rd. Balto. Md.

18. Funeral director: Frank J. Dewees
Address: Catonsville Md.

19. 9-18-46 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1946, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15 1946, to 9-15 1946 and that I last saw h[illegible] alive on 9-15 1946

Immediate cause of death: Fractured skull

Due to: Compound Comminuted Fracture, Rt Tibia & Fibula above ankle Comminuted Fractures of both legs, below knees & Left leg above ankle

Other conditions:

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9-15-46
Where did injury occur? Liberty Rd (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: Auto. Accident Injured at work? No

23. SIGNATURE: D. D. Caples, M.D. Exam. med.
M. D. or other
Address: Reisterstown, Md. Date signed: 9-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-A)

CERTIFICATE OF DEATH

Reg. Diat. No. 08774 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Baltimore

City or town Dundalk

(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? Only while working

Hospital, institution, or street address where death occurred: 6909 Dunmanway Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Fullerton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Magdidt Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry F. Eichler.

3.(b) Social Security Number 213-05-2508

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Eichler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/29/08

8. AGE: Years	Months	Days	If less than one day
38	5	19	..... hrs. ..... min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business Moving Co.

FATHER 12. Name Henry Eichler

13. Birthplace Balto. Md.

MOTHER 14. Maiden name Katherine Gottenson

15. Birthplace Germany

16. Informant Mrs. H. F. Eichler

Address Magidt Ave. Fullerton P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 20 46 (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto Md.

18. Funeral director Lansdale Funeral Home

Address 7401 Belair Rd.

19. Sept 19 1946 (Date rec'd by registrar) John S. Cornell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1946 to Sept 17 1946

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Carnuse M.D. M.D. or other

Deputy Medical Examiner

Address Dundalk Md. Date signed 9/17/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

08775

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
819 Frederick Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 819 Frederick Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Josephine Virginia Elmore

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Dorsey Elmore
Deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 16, 1868

8. AGE: Years	Months	Days	If less than one day
72	4	6	hrs. min.

9. Birthplace: White Stone, Virginia
(Town, county, and state)
10. Usual occupation: Practical Nurse
11. Industry or business
FATHER 12. Name: Joseph Doggett
13. Birthplace: White Stone, Va.
MOTHER 14. Maiden name: Virginia Beane
15. Birthplace: Virginia
16. Informant: Mrs. Pauline Somers
Address: Fort Jewell, Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27 1946 (month) (day) (year)
Cemetery or crematory: White Stone Baptist
Location: White Stone, Virginia
18. Funeral director: Easton Sons Md.
Address: 602 Frederick Ave. Catonsville
19. 9-26 1946 (Date rec'd by registrar) Harry Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1946, at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1936 to Sept. 24 1946
and that I last saw her alive on Sept. 24 1946

	DURATION
Immediate cause of death: Cerebral Hemmorhage	8 Days
Due to: Cardio-Vascular Renal Disease	8 yrs
Due to: Hypertension	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Roger E Moon MD M. D. or other
Address: Catonsville 28 Md Date signed: 9-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9350)

CERTIFICATE OF DEATH

08776

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Balto
City or town: Randallstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Chapman Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Randallstown (If outside city or town limits, write RURAL and give nearest town)
Street No.: Chapman Rd (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles T Emory

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Jennie V.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1881

8. AGE: Years	Months	Days	If less than one day
65	7	10	hrs. min.

8. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Agriculture
FATHER 12. Name: Hudson Emory
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary Elizabeth Boyer
15. Birthplace: Md.
16. Informant: Mr. Russell Emory
Address: Randallstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-46 (month) (day) (year)
Cemetery or crematory: Woods Chapel Cem.
Location: Liberty Rd. Balto. Co., Md.
18. Funeral director: C. Harry Weir
Address: Lyndsville, Md.
19. (Date rec'd by registrar) 19.... Registrar: Wm. E. Hunter

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 19 46, at 5 a above M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cardiac failure	
Due to: Cardio vascular disease	
Due to:	
Other conditions: Jaundice Jaundice	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Kierstead, Balto. M. D. or other
Address: 1010 Leadenhall Date signed: 9-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-6)

CERTIFICATE OF DEATH

Reg. Diat. No. 18777 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John B. Ensor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Married

6.(b) Name of husband or wife: Mary Elizabeth (nee Sparks)
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 25, 1969

8. AGE: Years: 77 Months: 2 Days: 3 If less than one day: hrs. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Farmer - Retired 10 yrs.
11. Industry or business
FATHER 12. Name: ~~John~~ Geo. Ensor
13. Birthplace: Balto. Co. Md.
MOTHER 14. Maiden name: Ruth Anna Ensor
15. Birthplace: Balto. Co. Md.
16. Informant: Lawrence E. Ensor
Address: Dowson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30 1946 (month) (day) (year)
Cemetery or crematory: St. Josephs
Location: Texas, Maryland
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.
19. Sept. 29 46 (Date rec'd by registrar) 19 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 1946, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/15 1944, to 9/28 1946
and that I last saw h. alive on 9/28 1946

	DURATION
Immediate cause of death: Carcinoma - (Primarily mastoid)	2 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D. (M. D. or other)
Address: Cockeysville Md. Date signed: 9/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BIRTH YEAR: STATEMENT OF FUNERAL DIRECTOR FILMED 9-25-46 C107 II

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08778

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewboro iofaote give resideoce of mother)
State: Maryland County: Baltimore
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2934 Baltimore Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHANNA ESSLINGER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Christian Esslinger
6.(c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.): 28 July 1858/ 1868

8. AGE: Years	Months	Days	If less than one day
78	1	19	********** hrs. ********** min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Henry Mellema
13. Birthplace: Germany

MOTHER
14. Maiden name: Dora Brandt
15. Birthplace: Germany

16. Informant: Mrs. Helen Wunder (daughter)
Address: 2934 Baltimore Ave.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 21 Sept. 46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Maryland

18. Funeral director: H. B. Hayden & Son.
Address: 1300 Eutaw Place...17

19. (Date rec'd by registrar) 9/20 1946 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 September 46-- 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10, 1946 to Sept 17, 1946 and that I last saw her alive on Sept 17 1946

Immediate cause of death	DURATION
Cerebral Hemmrrhage	1 week
Due to: Arteriosclerosis -	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Schofield MD M. D. or other
Address: 2301 Annapolis Road Date signed: 9/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

08779

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Pikesville (If outside city or town limits, write RURAL and give nearest town)
Street No. Orchard Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARTHA ELLEN FARLOW

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	M.

6.(b) Name of husband or wife ANDREW P. FARLOW
6.(c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) Feb. 15 / 1877

8. AGE: Years	Months	Days	If less than one day
75	7	13	hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Noah Sherman
13. Birthplace Virginia

MOTHER
14. Maiden name Edna Wetzel
15. Birthplace Virginia

16. Informant Mrs. Harry Raylor
Address Orchard Rd Pikesville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9-1-46 (month) (day) (year)
Cemetery or crematory Forest Ridge
Location Pikesville, Maryland
18. Funeral director Frank H. Mayer & Co.
Address Pikesville, Maryland

19. 9-30-1946 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to Sept. 1946 and that I last saw h[illegible] alive on Sept. 28 1946

Immediate cause of death	DURATION
Heart Failure	1 mo.
Due to Hypertension Cardio-vascular Disease.	1 year
Due to Chronic Myocarditis	
Other conditions Obesity. Aged. Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Louis J. Amand M. D. or other
Address Pikesville Md Date signed 9/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0878144

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos. 22 days
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? 5 mos & 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 Hornby St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Frank Fischer

3.(b) Social Security Number: 212-10-6071

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mildred Fischer
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Feb 6 1900.

8. AGE:	Years	Months	Days	If less than one day
	46	7	14	...hrs. ...min.

9. Birthplace: Baltimore City, (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Crown Cork & Seal.
FATHER 12. Name: Ernest Fischer.
13. Birthplace: Baltimore City
MOTHER 14. Maiden name: Mary Gephardt.
15. Birthplace: Baltimore City
16. Informant: Personal History- Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/46 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Dorsman Hill Rd.
18. Funeral director: John J. Connelly.
Address: 418 Eastern Ave. Essex 21
19. 9/22/ 19 46 (Date rec'd by registrar) John J. Connelly. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20 19 46, at 2:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 19 46 to Sept 20 19 46
and that I last saw h. alive on Sept 20 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis.	Feb 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other
Address: Towson 4, Maryland Date signed: 9-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Evidence for change of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4a)

CERTIFICATE OF DEATH

FILM No. I 07 OCT 8 1946

18781

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred: 617 "A" Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Sparrows Point Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 617 "A" Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Ellen Fitzgerald

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: John J Fitzgerald
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 3rd ~~1893~~ 1892

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	9			

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business: at home

FATHER
12. Name: Thomas Maley
13. Birthplace: Ireland

MOTHER
14. Maiden name: Delia Durkin
15. Birthplace: Ireland

16. Informant: Mr John J Fitzgerald
Address: 617 "A" Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/6/46 (month) (day) (year)
Cemetery or crematory: Holy Cathedral Cem.
Location: 4300 Old Frederick Rd.

18. Funeral director: John J Coyne & Son
Address: 901-03 Hollins St.

19. 9/4/46 19 (Signature of registrar) A. N. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3rd 1946, at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1946 to Sept 3 1946 and that I last saw h... alive on September 3 1946

Immediate cause of death	DURATION
Coronary Occlusion	3 hours
Due to: Coronary Artery disease	Chronic
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: 620 Dundalk Ave Apt 19 Date signed: 9.3.46

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43-H)

CERTIFICATE OF DEATH

08782

Reg. Diat. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 329 Westshire Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 329 Westshire Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Edward Flanigan

3.(b) Social Security Number: 214-03-0431

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Elizabeth M

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): March 26 1904

8. AGE:	Years	Months	Days	If less than one day
	42	5	29	...hrs. ...min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Driver

11. Industry or business: Nat Brewery

MOTHER FATHER

12. Name: John F Flanigan

13. Birthplace: Ireland

MOTHER

14. Maiden name: Tierney

15. Birthplace: Ireland

16. Informant: Elizabeth Flanigan

Address: 329 Westshire Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/27/46 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Balto Md.

18. Funeral director: Little's Funeral Home.

Address: 2700 Edmondson ave.

19. 9/25/46 19... (Date rec'd by registrar) A. W. Jedrusik Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1946 at about 1a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death: Asphyxiation

Due to: Illuminating Gas poisoning (self inflicted)

Due to:

Other conditions: Suicide

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: Sept 24 46

Where did injury occur? Catonsville (City or town) Balto (County) Md (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: turned burner on gas stove Injured at work? no

23. SIGNATURE: Geo McKie for Edward Wells M. D. or other

Address: 1010 Leadenhall Date signed: 9-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-G)

CERTIFICATE OF DEATH

08783 3 0
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 7 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Ellen Flemings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 22, 1895

8. AGE: Years	Months	Days	If less than one day
51	-	14	hrs. min.

9. Birthplace: Germany?
(Town, county, and state)

10. Usual occupation: Charwoman

11. Industry or business: Convalescent home

FATHER
12. Name: Ajacob Flemings
13. Birthplace: ?

MOTHER
14. Maiden name: Rose ?
15. Birthplace: ?

16. Informant: Hospital recordss

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1946 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 9-12 1946 (Date received by registrar) Harry J. Muller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1946, at 4:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1946 to September 5 1946 and that I last saw her alive on September 5 1946

Immediate cause of death	DURATION
Localized pelvic peritonitis	1 week
Chronic parenchymatous nephritis	Indefinite
Due to: Cerebral thrombosis	9 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 9-10-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

08784

CERTIFICATE OF DEATH

Reg. Diat. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Texcas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Texcas
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Josephine Ford

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Wm. Henry Ford —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1855

8. AGE:

Years	Months	Days	If less than one day
91	7	26	hrs. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business

FATHER
12. Name: Jacob Weaver
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Josephine —
15. Birthplace: Pennsylvania

16. Informant: James G. Ford
Address: Texcas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4 1946 (month) (day) (year)
Cemetery or crematory: Poplar
Location: Cockeysville, Md
18. Funeral director: Landon M. Bustes
Address: Sparks, Md.

19. 9-3 (Date rec'd by registrar) 19 46 Wilmer C. Enson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 19 46 at 7 15 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 15 19 40, to Sept 1 19 46
and that I last saw h... alive on 9/1 19 46.

Immediate cause of death	DURATION
Myocarditis	3 yrs.
Due to: Arteria sclerosis	
Due to: Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Enson M.D.
M. D. or other
Address: Cockeysville Md Date signed: 9/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 08785

1. PLACE OF DEATH: Co.
(a) Baltimore ~~City~~, Maryland
(b) Street address 534 S. 46th Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town ~~Balto.~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 534 S. 46th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Forster
3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-01-9197

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Stella Forster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/90

8. AGE: Years 56 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Shearman
11. Industry or business Stainless Steel

FATHER
12. Name Martin Forster
13. Birthplace —

MOTHER
14. Maiden Name Caroline Christ
15. Birthplace —

16 (a) Informant Mrs. C.A. Forster
(b) Address 534 S 46th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/46 (month) (day) (year)
(c) Cemetery or crematory Zion Luth. Cem.
Location Balto. Co. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) SEP 16 1946 (Date rec'd by registrar) (b) Registrar

Huntington Hillcrest, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15th 1946, at 2-40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1945 to 9/15 1946, and that I last saw h[illegible] alive on 9/1 1946

Immediate cause of death Carcinoma of tongue & lips — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place) Floor
(e) Means of injury —

23. Signature Charles A. Lowne M.D.
Address 321 S. Eutaw St. Date signed 9/16/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

08786

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Old Court Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Court Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clara S. Fryfogle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 9, 1879

8. AGE: Years	Months	Days	If less than one day
66	10	3	..... hrs. ..... min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Joseph A. Fryfogle
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden name: Elizabeth Baker
15. Birthplace: Baltimore County, Md.

16. Informant: Mr. Edward Fryfogle
Address: Old Court Rd., Randallstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 14, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18. Funeral director: Hillis Lamoreau

Address: 4510 Liberty Heights Ave.

19. 9/13/ 1946 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1946, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1946, to Sept. 12, 1946

and that I last saw her alive on Sept 12, 1946

Immediate cause of death	DURATION
Cardio-Vascular Dis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown, Md. Date signed 9/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

08787

★ Reg. Diat. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Falls Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lillian S. Gamble

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Edward B. Gamble

B.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1896

8. AGE: Years	Months	Days	If less than one day
50	7	6	....hrs. ....min.

9. Birthplace: Carroll Co., Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: William Sappington

13. Birthplace: Frederick Co., Md.

MOTHER

14. Maiden name: Fannie Baumgartner

15. Birthplace: Frederick ~~County~~ Co., Md.

16. Informant: E. B. Gamble

Address: Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6, 1946 (month) (day) (year)

Cemetery or crematory: St. Peter's

Location: Ilchester, Md.

18. Funeral director: Sanders M. Brooks

Address: Sparks, Md.

19. Sept. 5 19 46 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3 19 46 at 8:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 19 44, to Sept 3 19 46 and that I last saw h...ex...alive on 9/3 19 46

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to Rheumatism	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.

M. D. or other

Address: Catonsville Md. Date signed: 9/4/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

68788

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Balto

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Walker Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John W. Gantz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ida M Gantz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 5, 1861

8. AGE: Years	Months	Days	If less than one day
84	11	4	..... hrs. ..... min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business: Retired.

FATHER — 12. Name: Noah Gantz

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Leah Bubb

MOTHER — 15. Birthplace: Pa.

16. Informant: Nard Mr Gantz.

Address: 1227 Lake Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 12 1946 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville.

18. Funeral director: Schnorrenberg & Hamerman.

Address: 3615-17 Gertrude Ave.

19. 9-11-1946 (Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9, 1946 at 5.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1935 to Sept 9th 1946 and that I last saw him alive on Sept 9th 1946

Immediate cause of death	DURATION
Chronic Myocarditis	2 mons.
Due to: * Art. Sclerosis	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James A. Mueller M.D. M. D. or other

Address: Pikesville-8, Md Date signed: 9/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(462)

08789

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Parrows Point (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 812 "D" Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Parrows Point (If outside city or town limits, write RURAL and give nearest town)

Street No. 812 "D" Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Benjamin F. Garver

3.(b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Louise Garner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 8. 1866

8. AGE: Years: 80 | Months: — | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Jacob Garver

13. Birthplace

MOTHER 14. Maiden name: Elizabeth Musselman

15. Birthplace

16. Informant: Mrs. Lewis Futsell Address: Oak Grove Holly Drive Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/12/46 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Eastern Ave. Extended

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul st.

19. Sept 12 1946 (Date rec'd by registrar) John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 46 to Sept 10 19 46 and that I last saw h. alive on September 9 19 46

Immediate cause of death: Carcinoma of rectum — DURATION: 1 year

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury | Injured at work?

23. SIGNATURE: [illegible] M.D. M. D. or other

Address: 520 Parrows Pt. Md. Date signed: 9-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08790

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-2

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 412 North Colvin Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lena Genovese

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Antonio Genovese

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): December, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	?	...hrs. ...min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Salvatore Curreri

13. Birthplace: Italy

MOTHER 14. Maiden name: Dominoca ?

15. Birthplace: Italy

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30, 1946 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Belair Road

18. Funeral director: Joseph Forace Inc.

Address: 2013 Freemont Ave.

19. 9/27 1946 A.W. Hedrich Registrar

(Signature of local registrar)

Jr. E.

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1946 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 11 1946 to September 26 1946 and that I last saw h...er ...alive on September 26 1946

Immediate cause of death	DURATION
Acute exacerbation (half hour) of chronic myocardial insufficiency	Indef.
Due to: Chronic arteriosclerotic heart disease	"
Due to: Diabetes mellitus	"

Other conditions: Fracture of distal one-fourth of right ulna sustained 9-12-46, (noncontributory) Diagnosed and cast applied.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.

M. D. or other

Address: Catonsville-28, Md. Date signed 9-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

08791

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 649 Plymouth Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Marie Gohlke

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife JuliusGohlke
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) October 18, 1855

8. AGE: Years	Months	Days	If less than one day
90	10	22	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Jacob Volz
13. Birthplace Germany

MOTHER
14. Maiden name Margaret Geis
15. Birthplace Germany

16. Informant Mary Kullick
Address 649 Plymouth Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1946 (month) (day) (year)
Cemetery or crematory Lorraine
Location Balto. Co., Md.
18. Funeral director Mr. & Mrs. John W. Teufel & Son
Address 801 W. Fayette Street

19. 9/11/46 19..... A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26, 1946 to Sept. 9, 1946 and that I last saw her alive on Sept. 8, 1946

Immediate cause of death	DURATION
Cardiac Failure	
Due to Generalized Arteriosclerosis	
Due to Cerebral Hemorrhage	3/26/46
Other conditions Fractured hip,	
Due to: Accidental fall, suffered	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of August 17th, 1946
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) At home
Means of injury Accidental fall. Injured at work?

23. SIGNATURE George H. Krupp M.D.
M. D. or other
3030 Edmondson Ave. 9/9/46
Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92C)

CERTIFICATE OF DEATH

08792

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Opitz home
How long in hospital or institution? 4 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Millersculle R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Crain Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EMMA V. GREEN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles M. Green
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 21, 1865

8. AGE: Years	Months	Days	If less than one day
80	11	17	hrs. min.

9. Birthplace: Galbrills, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home
FATHER 12. Name: Lorenzo Lowman
13. Birthplace: Anne Arundel Co. Md.
MOTHER 14. Maiden name: Elegzeaner Short
15. Birthplace: Anne Arundel Co. Md.
16. Informant: Mr. Charles R. Green
Address: Millersville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11, 1946 (month) (day) (year)
Cemetery or crematory: Baldwin Memorial Ch. Yd.
Location: Millersville, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. Sept 10 1946 (Date rec'd by registrar) Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8 1946, at 1.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 20 1946, to Sept 8 1946
and that I last saw h. alive on Sept 7 1946.

Immediate cause of death	DURATION
Chr. Myocarditis	6 mon
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Glenarm Date signed 9-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

08793

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Phoenix (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Phoenix (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Poplar Hill Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ellen Virginia Gunn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Elmer D. Gunn
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1907

8. AGE: Years	Months	Days	If less than one day
38	11	8	hrs. – min.

9. Birthplace: a-a Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Van Shaney
13. Birthplace: a-a Co, Md.
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Elmer D. Gunn
Address: Phoenix, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12 1946 (month) (day) (year)
Cemetery or crematory: Poplar
Location: Phoenix, Md.
18. Funeral director: Landon M. Bishop
Address: Sparks, Md.
19. Sept. 12 19 46 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1946, at 1 A - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1946, to Sept 11 1946, and that I last saw h.er alive on 9/10 1946.

Immediate cause of death	DURATION
Carcinoma –	
(Primarily Uterine)	3 yrs –
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other
Address: Cockeysville Md. Date signed 9/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (149)

Registered No. [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Died in Ambulance
(c) Hospital or institution: at Chesaco Park, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 08794
(a) State MD. (b) County
(c) City or town 278 N. Exeter St. Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hale

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	COLORED	M.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-1914

8. AGE: Years	Months	Days	If less than one day
31	9	1	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business B+O RR.

FATHER
12. Name George Hale
13. Birthplace Pulaski, Va

MOTHER
14. Maiden Name Jessie Poole
15. Birthplace Va.

16 (a) Informant Miss Ella Saunders
(b) Address 127 St. Matthews St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Brooklyn, Md.

18 (a) Funeral director Elroy S. Wilson
(b) Address 1077 Brantley ave

19 (a) 10-5-46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946, at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1946, to 19, and that I last saw h[illegible] alive on Sept 29 1946.

Immediate cause of death	Duration
Fracture of Skull	
Internal injuries Chest & Abdomen	
Due to Struck by train	1
BROKE - Ft Jeffs Md.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Sept 29 1946 at 7 P M
(c) Where did injury occur? Woodlawn Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? RR Track While at work? No
(Specify type of place)
(e) Means of injury Struck by train
23. Signature H K Delaney M. D.
Address Aberdeen Md. Date signed 10-4-46

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-b)

CERTIFICATE OF DEATH

08795 38

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? Since Sept 12/46

Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since Sept 12/46

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Balto City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2713 N Pulaski (17) (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Alma M Hanson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edwin G Hanson

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): September 7, 1899

8. AGE:

Years	Months	Days	If less than one day
47	0	19	hrs. min.

9. Birthplace: Sweden (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Karl Alm

13. Birthplace: Sweden

MOTHER 14. Maiden name: Alma F Danielson

15. Birthplace: Sweden

16. Informant: Personal History-Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/46 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 9-27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1946, at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Sept 1946 and that I last saw her alive on September 25 1946

Immediate cause of death	DURATION
Due to: Pulmonary tuberculosis	Since Jan. 1946
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm A Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 9-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

08796

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Vets. Hosp. Fort Howard, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 639 W. Lexington St. Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American War

3.(a) FULL NAME
Samuel H. Harding

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Luella Harding
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 4-18-68

8. AGE:

Years	Months	Days	If less than one day
78	4	17	...hrs. ...min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace --

MOTHER
14. Maiden name Unknown
15. Birthplace ---

16. Informant Clinical Records
Address Vets. Adm. Hosp. Fort Howard, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 9-9-46
(month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Md.

18. Funeral director Oder Funeral Home Inc.
Address 4644 York Road, Baltimore, Md.

19. 9/9 (Date received by registrar) 1946 Hdw. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2 1946 to Sept. 5 1946 and that I last saw him alive on Sept. 5 1946

Immediate cause of death	DURATION
CARCINOMA OF BODY OF PANCREAS	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison M.D.
R.M. CULLISON, M.D. CLIN. DIR. or other
Address VA. Fort Howard, Md. Date signed 9/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 1 mo., 1 day
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 1 mo., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 Wise Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Henry Harmeyer

3. (b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 8, 1882

8. AGE: Years	Months	Days	If less than one day
64	6	28	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Huckster

11. Industry or business:

FATHER 12. Name: Antoine Harmeyer
13. Birthplace: Maryland

MOTHER 14. Maiden name: Catherine Whitman
15. Birthplace: Maryland

16. Informant: John H. Harmeyer
Address: 206 Wise Ave., Dundalk, Balto. Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/46 Md. (month) (day) (year)
Cemetery or crematory: Almshouse Cemetery
Location: Texas, Maryland

18. Funeral director: Frank Newell
Address: Pikesville, Maryland

19. 9/5/46 (Date rec'd by registrar) 19 Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5, 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1946 to Sept. 5, 1946 and that I last saw h. im. alive on September 5, 1946

Immediate cause of death	DURATION
Carcinoma of Esophagus	9 Mos.
Due to:	
Due to:	
Other conditions: Pulmonary Tuberculosis	About 3 or 4 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation. Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other
Address: Mt. Wilson, Md. Date signed: 9/5/46

Rec'd - 9-7-46 Dr E E Nichols mm.

2

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

08799

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1900 Sunbury Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1900 Sunbury Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Susie A Harris

3.(b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Joseph Harris
6.(c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) July 7 - 1884
8. AGE: Years 62 Months Days If less than one day ...hrs. ...min.
9. Birthplace Southfork Pa.
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business -
FATHER 12. Name Alfred Poling
13. Birthplace Pa.
MOTHER 14. Maiden name Laura L. ?
15. Birthplace Pa.
16. Informant Alfred P Harris (Son)
Address 1900 Sunbury Rd.
17. Removal. Date thereof 9/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Grandview Cem.
Location Johnstown Pa.
18. Funeral director John G Connelly.
Address 418 Eastern Ave. Essex 21
19. 9/17/1946 John G Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946, at 1 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4, 1945 19.., to Sept 16 1946
and that I last saw h... alive on Sept 14, 1946 19

	DURATION
Immediate cause of death Cerebral hemorrhage	1 hr
Due to Hypertension arteriosclerosis cardio-vascular disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Eugene F Nevy M.D.
M. D. or other
Address 7001 Harrington Rd Date signed 9-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 08800 30

P

1. PLACE OF DEATH:
County: Balto.
City or town: Villa Nova — Essex Rd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Robb Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary R. Hasslup

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: John L. M. Hasslup
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3/13/56

8. AGE: Years: 90 | Months: 6 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Edward Rider
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Rebecca A. McConkey
15. Birthplace: Balto. Co. Md.

16. Informant: Clinton M. Rider
Address: Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/21/46 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frd. Ave. Balto. Md.

18. Funeral director: John O. Mitchell Funeral Home
Address: 1600 Eutaw Place

19. 9/20 46 Geo. Heldrich Registrar
(Date rec'd by registrar)

DM

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 19 46, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-14 19 45, to 9-19 19 46 and that I last saw h-er alive on 9-18 19 46

Immediate cause of death	DURATION
Bronchial Pneumonia	3 days
Arteriosclerosis.	21 months
Due to: Hypertension C-V. Disease	21 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M. D.
M. D. or other
Address: Reisterstown, Md. Date signed 9-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49)

08801

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5500 Old Frederick road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MURIEL G. HENNESSEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Leroy J. Hennessey
6.(c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) August 9, 1899

8. AGE: Years	Months	Days	If less than one day
47	1	6	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Howard L. Wilson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden name Carrie Key
15. Birthplace Baltimore, Maryland

16. Informant Leroy J. Hennessey
Address 5500 Old Frederick road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/18/46 (month) (day) (year)
Cemetery or crematory New Cathedral
Location
18. Funeral director Chas. J. Evans & Son Inc
Address 118 N. Mt. Royal Ave.

19. 9/17 19 46 G. W. Hewitt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1943 19 to Sept 15 19 46
and that I last saw her alive on Sept 15-46 19

Immediate cause of death	DURATION
Carcinoma of the posterior vaginal wall.	3yrs.
Due to	
Due to	
Other conditions Chronic cholecystitis	6yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A Calais M. D. or other
Address 4 N. Fulton Ave Date signed 9/16/46

A.E. CALAS
4 N. FULTON AVE.

BALTIMORE CITY HEALTH DEPARTMENT (208) Registered No. 3808

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Abell's Estate, Bellona Ave.,
(c) Hospital or institution: Ruxton, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or daye)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 08802
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Bolton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE N. HILDRETH

3 (b) If veteran, name war	3 (c) Social Security Account No.
	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --------
6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1927

8. AGE: Years	Months	Days	If less than one day
17 (age at disappearance)		time	of hr. min.

9. Birthplace Charlottesville
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name William S. Hildreth
13. Birthplace Wheeling, W. Va.

MOTHER
14. Maiden Name Elizabeth Miche
15. Birthplace Charlottesville, Va.

16 (a) Informant Mrs. Elizabeth M. Hildreth
(b) Address 1517 Bolton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory --------
Location Charlottesville, Va.

18 (a) Funeral director W. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 (a) (10-8-46) (b) [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1946, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Undetermined
(Skeleton found after years of exposure --Identified by contour of skull, teeth, etc.)
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mackesy M.D.
Medical Examiner.
Date signed Sept. 27, 1946

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08803

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 25 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 4 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1026 E. Baltimore St.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Ida Israel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Jacob Israel

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): September 1875

8. AGE: Years	Months	Days	If less than one day
71			....hrs. ....min.

8. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: Hyman Margolis
13. Birthplace: Russia

MOTHER
14. Maiden name: Flora ?
15. Birthplace: Russia

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-4-46 (month) (day) (year)

Cemetery or crematory: Rosedale Cem.

Location: Hamilton Ave

18. Funeral director: J. J. Jennsen & Bros.

Address: 1126 N. Forth Ave.

19. 9-4 1946 Harry L. Miller
(Signature of registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 19 46 at 3:45p.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 9 19 46 to September 3 19 46 and that I last saw h er alive on September 3 19 46

Immediate cause of death	DURATION
Chronic Interstitial nephritis	Indef.
Due to: Chronic Arteriosclerotic Cardiovascular Disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: No.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk
Isadore Tuerk,
Catonsville 28, Md. M. D. or other

Address: Date signed 9/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08804

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yrs., 4 mos., 24 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 32 yrs., 4 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ?
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Timothy Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1873 ?

8. AGE:	Years	Months	Days	If less than one day
	73	?	?	hrs. min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: ?
FATHER 12. Name: ?
13. Birthplace: ?
MOTHER 14. Maiden name: ?
15. Birthplace: ?
18. Informant: Hospital records
Address: Catonsville-28, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-46 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland
18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland
19. 9-23 1946 (Signature of registrar) Harry G. Muller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1946, at 6:45 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1914, to September 14 1946 and that I last saw him alive on September 14 1946

Immediate cause of death	DURATION
Bilateral fibrotic pulmonary tuberculosis	Indefinite
Due to: Chronic interstitial nephritis	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other
Address: Catonsville-28, Md. Date signed: 9-19-46

VS A15 9-45.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

08805

CERTIFICATE OF DEATH

Reg. Diat. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Baltimore
Stay in hospital or inst. (yrs., or mos., or days) 10 yr. 5 mo. 1 da
Stay in this community (yrs., or mos., or days) 10 yr. 5 mo. 1 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Louis. Joria

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1871

8. AGE:

Years	Months	Days	If less than one day
74	11	18	hrs. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation Telegraph Operator
11. Industry or business
FATHER 12. Name Peter Joria
13. Birthplace Maryland.
MOTHER 14. Maiden name Mary A. Talley
15. Birthplace Virginia
16. Informant Mrs. Joria
Address 583 Frederick Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5 1946 (month) (day) (year)
Cemetery or crematory Mt. Olive
Location Roslyn Md.
18. Funeral director G. Howard Strong
Address 3207 W. North Ave
19. Sept. 3 1946 (Date rec'd by registrar) Wm. J. Chilcoat Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1946, at 9:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1936, to 9/2 1946, and that I last saw him alive on 9/2 1946.

Immediate cause of death	DURATION,
Coronary Thrombosis	15 min
Due to	
Due to	
Other conditions arthritis deformans - No use of Legs. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer C. Enson M.D. M. D. or other
Address Cockeysville Md. Date signed 9/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

08806

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Westowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Westowne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 209 Westowne Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nellye E. Kelly

3.(b) Social Security Number: 705-10-5621

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: - - - - -
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11, 1896

8. AGE: Years	Months	Days	If less than one day
50	3	5	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Western Md. R. R.

FATHER
12. Name: John J. Kelly
13. Birthplace: Ireland

MOTHER
14. Maiden name: Nellie E. Kelly
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Joseph R. Price
Address: 300 E. 32nd. St.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20, 1946 (month) (day) (year)
Cemetery or ~~crematory~~: New Cathedral
Location: Baltimore, Md.
18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.,

19. 9/19/46 (Date rec'd by registrar) A.W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

5.45

20. DATE OF DEATH: September 16, 1946, at ..... P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1938 to Sept 16 1946 and that I last saw h[er] alive on Sept 16 1946

Immediate cause of death: Asphyxiation from Status Epilepticus — DURATION: hours?

Due to: Grand Mal Epilepsy — 20 yrs?

Due to: Basilar Meningitis in childhood with Leptomeningeal Adhesions and Moderate degree of internal Hydrocephalus

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: William F. Knight M.D. M. D. Attender
Address: 10 E. Biddle St. Date signed: Sept 18 1946
Howard J. Stevens, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08807 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

42

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs 1
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 411 Wilkens ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marion A. Kilbourne

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Arthur M. Kilbourne
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years: 44 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Louis Lafferty
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Anabella McKinney
15. Birthplace: Beltsville, Md

16. Informant: Arthur M. Kilbourne
Address: 411 Wilkens ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 24 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore

18. Funeral director: Frederick A. Cole
Address: 1200 W. Lombard St.

19. 9-23 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1946 at 4:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1942 to Sept. 20 1946 and that I last saw her alive on September 20 1946

Immediate cause of death	DURATION
Essential Hypertension	4 yrs.
Cerebral Hemorrhage	1 hour
Due to: Generalized Arteriosclerosis	?
Due to:	
Other conditions: Obesity	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl Pass, M.D.
M. D. or other
Address: 4001 Wilkens Ave Date signed: 9-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

CERTIFICATE OF DEATH

08808 P

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 North East Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Lottie Virginia Klee

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John T. Klee
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): May 4 1874

8. AGE:	Years	Months	Days	If less than one day
	72	4	7	..... hrs. ..... min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Wm Moore
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Mary (unknown)
15. Birthplace: Baltimore Md

16. Informant: Hospital Records
Address: Catonsville, 28, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/14/46 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto. Md.

18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. 9/13/46 19..... A. W. Hedrick (registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1946, at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1946 to Sept 11 1946 and that I last saw h.. alive on Sept 11 1946

Immediate cause of death	DURATION
Cerebral thrombosis	Indef
Due to Generalized Arterio-sclerotic Cardio Disease	"
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Dudon Funk
Address: Catonsville 28 Md M. D. or other
Date signed: 9/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

08809

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred: 817 Rosedale street
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 817 Rosedale Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Mary Barbara Kohajda

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Antal
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nobember 14, 1881

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Checoslovika (Town, county, and state)
10. Usual occupation: Housewife at home
11. Industry or business:

FATHER
12. Name: Anton Novak
13. Birthplace: Check.

MOTHER
14. Maiden name: Frances Knapp
15. Birthplace: Check.

16. Informant: Antal Kohajda husband
Address: 817 Rosedale Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 / 10/46 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave, Ext'd.

18. Funeral director: Lilly & Zeiler Inc.
Address: 403 S. Wolfe Street

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 / 6 / 19 46 at 8:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 19 46 to Sept 6 19 46
and that I last saw her alive on Sept 6 19 46

Immediate cause of death	DURATION
Toxemia	2 wks.
Due to: Carcinoma of Cervix with Hepatic Metastasis	5 years
Due to:	
Other conditions: Jaundice	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo M Baumgardner M. D. or other
Address: Balto Md Date signed: 9-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

08810

Reg. Diat. No. 43

1. PLACE OF DEATH

County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
523 Elmwood Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 523 Elmwood Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ROSIE L KRACH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John L Krach

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 5 1869

8. AGE:

Years	Months	Days	If less than one day
77	8	24	..... hrs. ..... min.

9. Birthplace: Baltimore City Md
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: John Reichert
13. Birthplace: Germany

MOTHER
14. Maiden name: Rosie Hahn
15. Birthplace: Germany

16. Informant: Miss Marie Krach

Address: 523 Elmwood Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/46 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Balto Md

18. Funeral director: Lincoln Funeral Home

Address: 7401 Belair Road Balto 6 Md

19. Sept 30 (Date rec'd by registrar) 1946 Mo Q L Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/29/46 at 9:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 2 1946 to Sept 29 1946 and that I last saw h.. alive on Sept 29 1946

Immediate cause of death	DURATION
Chronic myocardial disease	4 yrs
Due to	
Due to	
Other conditions Cystic pulmonary edema	1 day

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A Lee Hutchins MD
M. D. or other

Address: 4116 Northern Parkway Date signed: 9/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

08811

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

Masonic Home, Cockeysville Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 S. Augusta Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Henry Kraft

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, Married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18 - 1873

8. AGE: Years	Months	Days	If less than one day
73	6	1	hrs. min.

9. Birthplace: Baltimore Md.

(Town, county, and state)

10. Usual occupation: Manager Lumber concern

11. Industry or business:

FATHER 12. Name: Henry Kraft

13. Birthplace: Wetteren, Germany

MOTHER 14. Maiden name: Louise Wagner

15. Birthplace: Allstedt, Germany

16. Informant: Laura M. Schroeder

Address: Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 23rd (month) (day) 1946

Cemetery or crematory: Baltimore Cemetery

Location: Baltimore Md

18. Funeral director: Wm. Cook

Address: St. Paul & Preston St

19. Sept. 20th 1946 (Date rec'd by registrar) L. M. Schroeder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19 1946, at 4 22 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1946, to Sept 19 1946

and that I last saw h... alive on Sept. 19 1946

Immediate cause of death	DURATION
Coronary Thrombosis	3 days
Due to: Hypertensive Cardio Vascular Disease	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walter T. Kreo M.D.

M. D. or other

Address: Powers ave, Cockeysville Date signed: 9/19/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08812

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto Co.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Berrymans Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gusta Ellen Mrs. Helland Kress

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Leonard G. Kress
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 27 - 1863

8. AGE: Years	Months	Days	If less than one day
83	5	12	hrs. min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Jacob W. Strine
13. Birthplace: Fred. Co. Md.
MOTHER 14. Maiden name: Susan Stultz
15. Birthplace: Fred. Co. Md.
16. Informant: Mrs. Bertie M. Barnhart
Address: Reisterstown, Balto. Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12-1946 (month) (day) (year)
Cemetery or crematory: Bailis Cem.
Location: Marston, Carroll Co. Md.
18. Funeral director: H Bankard & Son
Address: Westminster, Md.
19. Sept. 9 1946 (Date rec'd by registrar) Mary B. Elmore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1946, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-11 1945, to 9-9-1946
and that I last saw h. alive on 9-9-46 19..

Immediate cause of death	DURATION
Bronchio Pneumonia	2 da.
Due to: Senile Degeneration due to arteriosclerosis	6 wks.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. D. Eagles, M. D.
M. D. or other
Address: Reisterstown, Maryland Date signed: 9-9-46

08813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 8 months, 17 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 1 year, 8 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1019 Forrest Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Leroy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8, 1857

8. AGE: Years	Months	Days	If less than one day
89	6	21	hrs. min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: ?
FATHER 12. Name: ?
13. Birthplace: ?
MOTHER 14. Maiden name: ?
15. Birthplace: ?
16. Informant: Hospital records
Address: Catonsville-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof October 2, 1946 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland
18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland
19. 10 — 2 — 1946 (Date rec'd by registrar) Harry H. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 1946 at 7:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1945 to September 29 1946 and that I last saw him alive on September 29 1946

	DURATION
Immediate cause of death: Coronary thrombosis	indefinite
Due to: Hypertensive arteriosclerotic cardiovascular-renal disease-	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk
Isadore Tuerk, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 9-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

★ 08814 Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 20 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-17
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2032 Linden Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Liebe Liebowitz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife: Reuben Liebowitz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	?	?		

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Isadore Golfonse
13. Birthplace: Russia

MOTHER
14. Maiden name: Goldie Noami
15. Birthplace: Russia

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-7-46 (month) (day) (year)

Cemetery or crematory:

Location: Hebrew Mt Carmel

18. Funeral director: Jack Lewis Inc

Address: 1439 E Baltimore St

13. 9-4 1946 (Date rec'd by registrar) Harry G. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 1946, at 6:06 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Coronary occlusion

Due to: Cardiac vascular disease

Due to:

Other conditions: sudden death Inquiry

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Kieffer Jr. M.D. Left Med Exam Hall M. D. or other

Address: 1010 Leed and Date signed: 9-7-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Name 08815

Reg. Dist. No. 31

1. PLACE OF DEATH

County Baltimore

City or town Larchmont

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md. County Baltimore

City or town Larchmont

(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Locust Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Vernon Jerome Lockard.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Margaret Lockard

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 27 1891

8. AGE: Years	Months	Days	If less than one day
55	5	11	hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Court House Towson Md.

FATHER

12. Name William E. Lockard

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Rosanna Hooper

15. Birthplace Carroll Co. Md.

16. Informant Mrs. Mary M. Lockard

Address 103 Locust Drive Larchmont Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10 1946 (month) (day) (year)

Cemetery or crematory Druid Ridge Cem.

Location Pikesville Md.

18. Funeral director E. Wells Lamorgan

Address 4510 Liberty Hghts. Ave.

19. Sept 10 1946 Herman A. Brunn Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7th 1946 at 7 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13/46 19 to Sept 7/46 19

and that I last saw h. alive on Sept 7/46 19

Immediate cause of death

Cardio Vascular disease — DURATION ?

Coronary thrombosis — Jan 13/46

Due to

Due to

Other conditions Myocardial damage — Jan 13/46

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

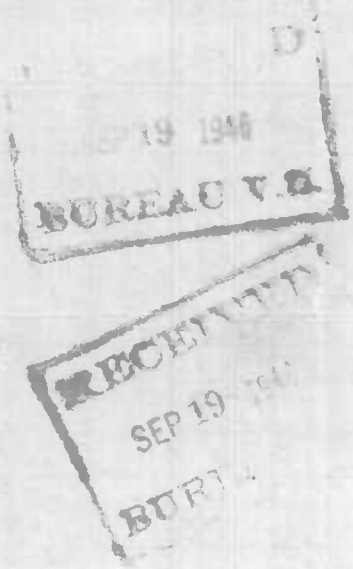
23. SIGNATURE Hallet D. Hubbard M. D. or other

Address 7770 Garrison Blvd. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

08816

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5-2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Eliza Owens Marsden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Joshua M. Marsden
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 29 July 1860

8. AGE: Years	Months	Days	If less than one day
86	1	29	..... hrs. ..... min.

9. Birthplace Catonsville Maryland (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
12. Name of father Samuel W. Owens
13. Birthplace of father Maryland
14. Maiden name of mother Sarah Winter
15. Birthplace of mother Maryland
16. Informant Sarah Peddicord
Address 29 Newbury Ave, Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-1-46 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Gate to City
18. Funeral director Edw. S. McCabe
Address Catonsville Md.
19. 10-1-1946 (Date rec'd by registrar) Harry D. Muffin Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1946, at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1934, to Sept. 28 1946
and that I last saw h.. alive on Sept. 28 1946

	DURATION
Immediate cause of death: Myocarditis	4 mos
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE C Wimber Ford M. D. or other
Address 20 E. Preston St. Date signed 9/30/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

08817 P

Reg. Dist. No.....

1. PLACE OF DEATH:
County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
128 Rosewood Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 Rosewood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MARY E. MASSEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Howard J. Massey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 8, 1871

8. AGE: Years	Months	Days	If less than one day
~~75~~ 75	4	0	..... hrs. ..... min.

9. Birthplace Martinsburg, W. Va. (Town, county, and state)
10. Usual occupation --
11. Industry or business --

FATHER
12. Name William Smith
13. Birthplace Martinsburg, W. Va.

MOTHER
14. Maiden name Anna Hess
15. Birthplace Martinsburg, W. Va.

16. Informant Mr. Howard J. Massey
Address 128 Rosewood Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/11/46 (month) (day) (year)
Cemetery or crematory Green Hill Cem.
Location Martinsburg, W. Va.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 9/10/46 (Date rec'd by registrar) 19.....
R. W. Hedrick Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 19 46, at 11:35p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 19 46 to Sept 8 19 46
and that I last saw h~~e~~r alive on Sept. 8 19 46

Immediate cause of death	DURATION
Chronic Myocarditis	6 mos.
Due to Arteriosclerosis	?
Due to	
Other conditions Two previous cerebral hemorrhages. (Include pregnancy within 3 months of death)	15 years.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. Walter Spurrier M.D. M. D. or other
Address 3603 Edmondson Ave Date signed 9/9/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

U8818 30

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two months

Hospital, institution, or street address where death occurred:
Carter Nursing Home, Catonsville, Md.

How long in hospital or institution? Two months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3047 Brighton St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Loleta Noland Meyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife Robert A. Meyer

B.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) January 9, 1871

8. AGE: Years	Months	Days	If less than one day
75	8	10	....hrs. ....min.

9. Birthplace Middleburg, Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Berkley Noland

13. Birthplace Middleburg, Va.

MOTHER 14. Maiden name Lucy C. Chinn

15. Birthplace Middleburg, Va.

16. Informant Robert A. Meyer

Address 3047 Brighton St., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19, 1946. (month) (day) (year)

Cemetery or crematory Sharon Cemetery, Middleburg, Va.

Location

18. Funeral director John O. Mitchell & Sons Co.

Address 1900 Eutaw Place

19. 9-19 1946 (Date rec'd by registrar) Harry D. Zufler Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19th 1946, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1946, to Sept 19th 1946

and that I last saw h[er] alive on Sept 19th 1946

Immediate cause of death	DURATION
Bronchopneumonia	24 hrs
Due to Cardiac failure	2 days
Due to Hypertensive cardiovascular disease	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Helen T. Sullivan M. D. or other

Address 6 E. Biddle St. Date signed 9/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6819 P

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution? 62 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Route #2, Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3. (a) FULL NAME: JAMES EDWARD MICKENS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Catherine Mickens

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): 7-31-1921

8. AGE: Years	Months	Days	If less than one day
25	1	24	..... hrs. ..... min.

9. Birthplace: Ilchester, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: James R. Mickens

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Annie Wilson

MOTHER — 15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/29/46 (month) (day) (year)

Cemetery or crematory: St. Stevens Cemetery

Location: St. Stevens, Howard Co., Md.

18. Funeral director: Charles R. Law

Address: 802 Madison Avenue

19. 9/27/46 (Date rec'd by registrar) 19.....

A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 19 46 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1946, to Sept. 25 1946 and that I last saw him alive on September 25 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 Yrs.
Due to	
Due to	
Other conditions: Amputation stump rt. fore arm. (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P/S Robert M. Cullison M. D. or other
R. M. CULLISON, M.D. CLIN. DIR.

Address: V. A., Ft. Howard, Md. Date signed: 9-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 088201 4

1. PLACE OF DEATH:

County Balto - 19.

City or town Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life.

Hospital, institution, or street address where death occurred: 151 Oak Ave.

How long in hospital or institution? ——

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ...... County ......

City or town As in #1.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ......
(If rural, give LOCATION)

2.(a) If veteran, name war ......

3.(a) FULL NAME Ernestine Clara Morgan.

3.(b) Social Security Number ......

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single.

6.(b) Name of husband or wife ——

6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Sept. 29. 1946.

8. AGE: Years ...... Months ...... Days ...... If less than one day: 1 hrs. ...... min.

9. Birthplace as in #1.
(Town, county, and state)

10. Usual occupation none

11. Industry or business ......

FATHER — 12. Name: Sherman Waverly Morgan

13. Birthplace: Culpepper. Va.

MOTHER — 14. Maiden name: Vonzella Mae Frisby.

15. Birthplace: Balto. Md.

16. Informant: Vonzella Morgan.

Address: as in #1.

17. Burial — Date thereof Sept. 30 '46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem

Location: A. A. County Md

18. Funeral director: Mrs. Robert A. Elliott Agt

Address: 1129 N. Carlin St

19. 9-30 ...... 19 ...... [signature] DM Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1946, at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29 1946, to Sept 29 1946.
and that I last saw her alive on Sept 29. 1946 19......

Immediate cause of death: Premature - (5 month pregnancy). — DURATION ......

Due to ......

Due to ......

Other conditions ......
(Include pregnancy within 3 months of death)

Major findings of operations ......

...... Date of op. ......

Autopsy results ......

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ...... Date of ......

Where did injury occur? ...... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ......

Means of injury ...... Injured at work? ......

23. SIGNATURE Louis N. Tollin Md — M. D. or other

Address Sparrows Point — Date signed 9/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

68821

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Balt Co.
City or town: Gittings Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Gittings Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John A. Mumma

3. (b) Social Security Number: 220-01-0226

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 16 - 1869

8. AGE: Years 77 | Months 1 | Days | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Md

16. Informant: Odila Faudner
Address: Glenarm Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 9-1946 (month) (day) (year)
Cemetery or crematory: Prangl Chapel Cem
Location: Glenarm Md.

18. Funeral director: Clarence E. Arthur
Address: Fork Md

19. Sept 7 1946 (Date rec'd by registrar) C. E. Arthur Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 19 46 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 19 42 to Sept. 6 19 46 and that I last saw h alive on August 28 19 46

	DURATION
Immediate cause of death: Coronary Thrombosis	15 Min.
Due to: arteriosclerotic Heart Disease	4 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D. M. D. or other
Address: Fork, Md. Date signed 9/7/46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on FILM No. I 07 SEP 16 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08822 VP

(930)

Reg. Diat. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Kenwood & McCormick

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Virginia M Ningard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Arthur C Ningard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4 1857

8. AGE: Years	Months	Days	If less than one day
88- 89	5		hrs. min.

9. Birthplace: Virginia

(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: James L Robinson

13. Birthplace: Va

MOTHER 14. Maiden name: Don't know

15. Birthplace: Va

16. Informant: Arthur C Ningard

Address: 1013 N Broadway

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept 7 1946 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Baltimore Md

18. Funeral director: Ullrich Funeral Home

Address: 2008 Orleans St

19. 9/6/46 (Date rec'd by registrar) A. H. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1946 at 1.15am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/26 1946 to 9/5 1946 and that I last saw h.er alive on 9/4 1946

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Arteriosclerotic cardio-vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Christian F. Reisz M. D. or other

Address: 1700 St Paul St. Date signed: 9/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47a)

CERTIFICATE OF DEATH

L8823 42 P

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Baltimore Highlands - Zone 27

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution, or street address where death occurred:

3014 Illinois Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto Co

City or town Baltimore Highlands

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3014 Illinois Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daniel Leo O'Brien

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married -

6.(b) Name of husband or wife Ella W. O'Brian

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Aug. 7 - 1875

8. AGE: Years	Months	Days	If less than one day
71	1	19	hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Night Watchman

11. Industry or business Bank -

FATHER 12. Name Daniel O'Brien

13. Birthplace Balto., Md.

MOTHER 14. Maiden name Mary Jenkins

15. Birthplace Balto., Md.

16. Informant Mrs. Ella W. O'Brien

Address 3014 Illinois Ave., Balto. Hglnds.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/46 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 9-27 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 19 46 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 19 46 to Sept. 26 19 46

and that I last saw h. alive on Sept. 26 19 46

Immediate cause of death	DURATION
Cardio - Vascular Disease	2 days.
Due to	
Due to	
Other conditions Cancer of Larynx.	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M.D. M. D. or other

Address Linthicum Date signed 9-26-46

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 12

1 PLACE OF DEATH

County Balto.

Village or City Emerson (No. 2 Beach Drive St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Olaf Eloen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Widower

6 DATE OF BIRTH: Mar. (Month) 11 (Day), 1889 (Year)

7 AGE: 57 yrs. 6 mos. 11 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Watch Tender
(b) General nature of industry business, or establishment in which employed or (employer) Sparrows Pt.

9 BIRTHPLACE (State or country) Norway

PARENTS

10 NAME OF FATHER Eloen

11 BIRTHPLACE OF FATHER (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (State or Country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant Christoffer Christoffersen)

(Address) 127 N. Streeper St.

15 Filed 9-24 1946 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 22, 1946

9 (Month) 22 (Day) (Year) 46

17 I HEREBY CERTIFY, That I attended the deceased from June 1946 to Sept 21, 1946 that I last saw him alive on Sept 21, 1946 and that death occurred on the data stated above, at 3 P. m.

The CAUSE OF DEATH * was as follows:

Cardiac

(Duration) 2 yrs. 3 mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Harry Hubert M. D.

9/22 1946 (Address) 109 Trapfe Road

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Balto. National Cem. DATE OF BURIAL: Sept. 25, 1946

20 UNDERTAKER: John L. Miller ADDRESS: 2331 Jefferson St.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-4)

CERTIFICATE OF DEATH

C8825

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7014 Windsor Mill Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7014 Windsor Mill Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward L. Oursler

3.(b) Social Security Number: 212-05-5974

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Clara May Oursler

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): August 27, 1881

8. AGE:

Years	Months	Days	If less than one day
65	1	2	hrs. min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Lineman

11. Industry or business: Consol. Gas & Elec. Co.

FATHER

12. Name: Thomas F. Oursler

13. Birthplace: Carroll County, Md.

MOTHER

14. Maiden name: Harriett M. Monroe

15. Birthplace: Carroll County, Md.

16. Informant: Mrs. Edward L. Oursler

Address: 7014 Windsor Mill Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18. Funeral director: Miller Funeral

Address: 4510 Liberty Heights Ave.

19. 10/1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 19 46 at 9.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 19 46 to Sept 29 19 46

and that I last saw him alive on Sept 29 19 46

Immediate cause of death	DURATION
Acute Dilatation of Heart & Pulmonary Oedema	2 days
Due to: Myocardial Infarction	4 years
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. C. Smith M. D. or other

Address: 4509 Liberty Hgts Ave. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08826

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Hampton Annex, Dulaney Valley Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fulton Ave. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Anna Lou Parlow

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Abraham G. Parlow
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): February 8, 1915

8. AGE: Years	Months	Days	If less than one day
31	7	22	— hrs. — min.

9. Birthplace: Millersville, Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: John Reuben Carter
13. Birthplace: Tennessee

MOTHER
14. Maiden name: Jane R. Hartsock
15. Birthplace: Virginia

16. Informant: Abraham G. Parlow
Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 4, 1946 (month) (day) (year)
Cemetery or crematory: Mays Chapel Cem.
Location: Timonium, Balto. Co., Md.

18. Funeral director: John Burns Sons
Address: Towson, Md.

19. Oct. 3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30 1946, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1945, to Sept 30 1946, and that I last saw h.e.r. alive on Sept 27 1946.

Immediate cause of death	DURATION
Heart disease, coronary occlusion	1 day
Due to: Chronic myocarditis	1 yr.
Due to: Asthma, bronchial	4 yr. +
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rollin C. Hudson M.D.
M. D. or other
Address: Towson, Md. Date signed: 10/1/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08827

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs., 29 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 40 years, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: ?
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Parsons

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Henrietta Callender
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1864

8. AGE: Years	Months	Days	If less than one day
82	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: ?
11. Industry or business: ?
FATHER 12. Name: ?
13. Birthplace: ?
MOTHER 14. Maiden name: ?
15. Birthplace: ?
16. Informant: Hospital records
Address: Catonsville-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-46 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland
18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland
19. 9-23 (Date received by registrar) 1946 Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1946, at 8:00 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 1906, to September 12 1946 and that I last saw him alive on September 12 1946

Immediate cause of death	DURATION
Cerebral thrombosis	indefinite
Due to: Hypertensive cardiovascular disease	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Isadore Tuerk

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 9-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

08828 Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 N Beechwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME George Albert Rackensperger
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mary A
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug. 31, 1873
8. AGE: Years 73 Months = Days 26 If less than one day ... hrs. ... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Bank Watchman
11. Industry or business
FATHER 12. Name Daniel W Rackensperger
13. Birthplace Germany
MOTHER 14. Maiden name Francis Scharold
15. Birthplace Maryland
16. Informant Mr Henry Rackensperger
Address 305 N Beechwood Ave
17. Burial Date thereof 9-30-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cathedral
Location Baltimore Md
18. Funeral director Geo. A. Farley
Address Catonsville Md
19. 9-28-1946 Harry J. Miller Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1946, at 8-30 am M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to Cardio vascular disease	
Other conditions Sudden death Inquiry	
(Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Geo M Kieffer Dep. Med. Exam. of Balto Co. M. D. or other
Address 1010 Leeds Ave Date signed 9.26.46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-L)

CERTIFICATE OF DEATH

08829 Reg. Dist. No. 43

P

1. PLACE OF DEATH:
County Baltimore
City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 Leslie Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Julius A. Rippinger

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mamie Rippinger
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26, 1890

8. AGE: Years	Months	Days	If less than one day
56	5	22	..... hrs. ..... min.

9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual occupation Engineer
11. Industry or business
FATHER 12. Name Conrad Rippinger
13. Birthplace Germany
MOTHER 14. Maiden name Sophia Babics
15. Birthplace Germany
16. Informant Mrs Mamie Rippinger
Address 111 Leslie Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21, 1946 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Colgate Md
18. Funeral director Ulrich Funeral Home
Address 209 E Preston St
19. 9/20 19 46 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1946, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944, to Sept 18 1946
and that I last saw him alive on Sept 18 1946

Immediate cause of death	DURATION
Pulm. Edema	8 hrs.
Due to Hypertensive Cardio-vascular disease	6 years
Due to Essential hypertension	
Other conditions Coronary arteriosclerosis	6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W H Fuller M.D. M. D. or other
Address Ridge Road Post-6 Md Date signed 9/18/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-8)

08830

CERTIFICATE OF DEATH

Reg. Dist. No. KK

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2122 Calvert Street (If rural, give LOCATION)

2.(a) If veteran, name war SAW

3.(a) FULL NAME JOHN E. RITTENHOUSE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-18-1874

8. AGE: Years	Months	Days	If less than one day
72	6	26	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Nicholas Rittenhouse

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Emma Ommensetter

15. Birthplace Pennsylvania

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17/46 (month) (day) (year)

Cemetery or crematory Private Cemetery-Loudon Park

Location Baltimore, Maryland

18. Funeral director John O. Mitchell & Sons

Address Baltimore, Maryland

19. 9/16 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1946, at 9:25 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 2 1946, to September 14 1946 and that I last saw h. im alive on September 14 1946

Immediate cause of death	DURATION
UREMIA, ACUTE	9 days
Due to Nephritis, Chronic	1½ yrs pls
Due to	
Other conditions Ulcer, Peptic	
Anemia, secondary	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
M. D. or other

Address VA Fort Howard, Md. Date signed 9-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (924)

08831

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkton.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Baltimore.
City or town: Parkton.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George W. Roache.-

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife: Lillie Bull Roache.-
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 21, 1860

8. AGE:

Years	Months	Days	If less than one day
86	3	2.	..... hrs. ..... min.

9. Birthplace: Parkton, Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Retired Farmer.
11. Industry or business: Own farm.

FATHER
12. Name: Jesse Roache.-
13. Birthplace: Md.

MOTHER
14. Maiden name: Lavina Cooper.-
15. Birthplace: Md.

16. Informant: Mrs. Thomas Armacost
Address: Parkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 25 1946. (month) (day) (year)
Cemetery or crematory: Wiseburg.
Location: Parkton, Md. R.D.

18. Funeral director: Jacob Hartenstein
Address: New Freedom, Pa.

19. Sept 23 1946 (Date rec'd by registrar) Catherine L. Feaser Deputy Licensed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23, 1946, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Sept 23 1946
and that I last saw him alive on Sept 22 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 day
Due to Chronic valvular heart disease	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilbur Bortner M. D.
M. D. or other
Address: White Hall Date signed: Sept 23

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08832

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Sutherville (Rural)
(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sutherville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pleasant Spring Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Joseph Walter Scott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1925

8. AGE: Years	Months	Days	If less than one day
20	11	27	hrs. min.

9. Birthplace: Balto Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Joseph Harold Scott

13. Birthplace: Balto Co., Md.

MOTHER 14. Maiden name: Oline M. Robinson

15. Birthplace: Balto Co. Md.

16. Informant: Jos. H. Scott

Address: Sutherville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1 Sept. 13, 1946 (month) (day) (year)

Cemetery or crematory: Black Rock

Location: Balto Co. Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 9-13 46 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-10-46 19 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 9-10-46 19

and that I last saw him alive on 9-13-46 19

Immediate cause of death	DURATION
Myasthenia Gravis	8 yrs.
Due to	
Due to	
Other conditions Chronic Myocarditis. Duration, ten years, cardiac	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James G. Scott M. D. or other

Address: Reisterstown Md. Date signed: 9-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-4)

CERTIFICATE OF DEATH

08833 P

Reg. Dist. No. 30

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Floral Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Floral Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Ingleside Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Roberts Sears

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 25, 1864

8. AGE: Years	Months	Days	If less than one day
82	2	4	hrs. min.

9. Birthplace: Queen Anne Co., Md.
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: William Thomas Sears
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth E. Crier
15. Birthplace: Md.

16. Informant: Mr. Lloyd E. Sakers
Address: Ingleside Ave.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2, 1946 (month) (day) (year)
Cemetery or crematory: Lorraine Park
Location: Woodlawn, Md.
18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.
19. 10/1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29, 1946, at 2.20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1944 to Sept. 29 1946 and that I last saw him alive on Sept 29 1946
Immediate cause of death: Coronary Thrombosis — DURATION: 24 hrs.
Due to: Myocardial Degeneration — 2 Yrs.
Due to: Arteriosclerosis. — 11 yrs.
Other conditions: Arterial Hypertension — 1 yrs.
Senility
(Include pregnancy within 3 months of death)
Major findings of operations: no operation
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joshua H. Armacost M.D.
M. D. or other
Address: 6419 Windsor Mill Rd. Baltimore-7
Date signed: Sept 30 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-6

08834

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 2 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 W. Lee St., Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Grace Virginia Sexton

3.(b) Social Security Number: 220-02-802

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas W. Sexton

7. Birth date of deceased (mo., day, yr.): ~~Sept. 12, 1921~~ Baltimore, Maryland

6.(c) If alive, give age: 36 years

8. AGE:

Years	Months	Days	If less than one day
25	0	1	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Trigger
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Lula Harris
15. Birthplace: Baltimore, Maryland

18. Informant: Thomas W. Sexton
Address: 4934 Pennington Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16, 1946 (month) (day) (year)
Cemetery or crematory: Holy Cross Cemetery
Location: Anne Arundel Co., Maryland

18. Funeral director: John F. Denny
Address: Light & Montgomery Sts., Balto., Md.

19. Sept. 13, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1946 at 6:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11, 1946 to Sept. 13, 1946 and that I last saw her alive on September 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Enteritis	Unknown
Myocardial Insufficiency	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 9/13/46

Recd 9-16-46 Dr E E Nichols mm

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 0883544

Reg. Diat. No.

PLACE OF DEATH:
City Baltimore Country
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital, Ft. Howard, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 736½ W. Lexington St., Balto-23-Md.
(If rural, give LOCATION)
2.(a) If veteran, name war WWI

3.(a) FULL NAME
SHIELDS, Clarence R.

3.(b) Social Security Number
719-14-6587

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife Hazel Shields
6.(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) 7/4/91

8. AGE: Years	Months	Days	If less than one day
55	1	27	....hrs. ....min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business
FATHER 12. Name deceased
13. Birthplace
MOTHER 14. Maiden name deceased
15. Birthplace
16. Informant Clinical Records
Address Vets. Adm. Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/46 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland
18. Funeral director Charles A. Law
Address 802 Madison Ave, Balto, Md.
19. 9-3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1946 at 6:00A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....1946...., to ....1946....
and that I last saw him alive on 1947 1946
Immediate cause of death BRONCHIAL PNEUMONIA BILATERAL — DURATION 8 days
Other Conditions 28 t
Malarial fever quartan about — 4 wks
Spastic paralysis trunk & legs cause undetermined — 10 mos.
Other conditions 82a
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison M.D. or other
R.M. CULLISON, M.D. Clinical Director
Address V.A. Hospital, Ft. Howard, Md. Date signed 9/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and legib

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08836 31
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Colonial Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Colonial Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: FREDERICK G. SIPES

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1873

8. AGE: Years	Months	Days	If less than one day
72	8	22	hrs., min.

9. Birthplace: Calverton, Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: John W. Sipes
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Victorine Gordshell
15. Birthplace: Md.

16. Informant: Mrs. Bertha Sipes
Address: Colonial Rd., Woodlawn 7, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/46 (month) (day) (year)
Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 9/17 19 46 (Date rec'd by registrar) Aw. Hydrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 14, 19 46 at 4:35p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 19 46 to Sept 14 19 46 and that I last saw h[illegible] alive on Sept 14 19 46

Immediate cause of death	DURATION
Chronic obstructive heart dis	
Due to	
Due to	
Other conditions Coronaria prostat	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Ernest W. Kahn, M. D. M. D. or other
Address: 1735 Pop Gr Ln Date signed 9/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-A)

CERTIFICATE OF DEATH

08837

Reg. Dist. No. 8X

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 hours

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution? 2 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1349 Stockland ~~land~~ ton Street
(If rural, give LOCATION)

2.(a) If veteran, name war WW II

3.(a) FULL NAME JOHN W. SMITH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Mrs. Ruth Smith

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 12-3-1903

8. AGE: Years	Months	Days	If less than one day
42	9	15	...hrs. ...min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Clinical Records, Vets.Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-46 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director Wm. A. Jackson

Address 916 Penn. Ave., Balto., Md.

19. 9/20 19 46 A.G. Hedrick Sm. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 19 46 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18 19 46 to Sept. 18 19 46 and that I last saw h...im...alive on September 18 19 46

Immediate cause of death	DURATION
Rupture of Congenital aneurysm of right anterior cerebral artery	10 Hrs.
Due to	
Due to	
Other conditions Hypertension	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE was Robert M Cullison M. D. or other
R. M. CULLISON, M.D. CLIN. DIRECTOR

Address V.A., Ft. Howard, Md. Date signed 9-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

~~G44184~~ ~~G44184~~ Co

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1

0C08841 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Co.
(a) Baltimore ~~City~~, Maryland
(b) Street address 4311 Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stephen Snyder

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-01-7026

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Marr
6 (b) Name of husband or wife: Marie Snyder
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 26
8. AGE: Years 60 Months Days If less than one day hr. min.
9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Michael Snyder
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna Raubach
15. Birthplace Germany

16 (a) Informant Mrs Marie Snyder
(b) Address 4311 Kenwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1-46 (month) (day) (year)
(c) Cemetery or crematory Moreland Pk
Location
18 (a) Funeral director Jos J Sterr + Son
(b) Address 3001 Kentucky Ave
19 (a) SEP 30 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1946, at 12:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1946, to Sept 28 1946, and that I last saw him alive on Sept 28 1946.

Immediate cause of death	Duration
Coronary Occlusion	Unknown
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

PHYSICIAN: Underline the cause to which death should be charged statistically.

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adam J. Lewis M. D.
Address 6232 Belair Road Date signed Sept 29, 1946

VS 150 1885-9A28dd

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

08838

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 months, 17 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year, 11 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town: Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Speith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Kate Lesh

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27, 1860

8. AGE: Years	Months	Days	If less than one day
86	4	1	hrs. min.

9. Birthplace: Cleveland, Ohio (Town, county, and state)

10. Usual occupation: Sawmill work

11. Industry or business: Sawmill

FATHER — 12. Name: John G. Speith

13. Birthplace: Germany

MOTHER — 14. Maiden name: Christina Slenth

15. Birthplace: Belgium

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 9, 1946 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 10-9 1946 (Date rec'd by registrar) Harry H. Fuller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 1946, at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 1944, to September 28 1946 and that I last saw him alive on September 28 1946

Immediate cause of death	DURATION
Gangrene of the right foot, sepsis	1 week
Due to: Generalized arteriosclerosis	Indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuark, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 10-7-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 08839

P

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Filmar Place
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Herman H. Spencer

3.(b) Social Security Number 212-10-7495

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Blanche Spencer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) April 7-1890

8. AGE: Years	Months	Days	If less than one day
56	5	16	..... hrs. ..... min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual occupation Steel room Clerk
11. Industry or business Brown Cork & Seal Co.
FATHER 12. Name Amos Spencer
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Evans
15. Birthplace Maryland
16. Informant Mrs. Blanche Spencer
Address Cockeysville, Maryland
17. Burial Date thereof Sept. 23-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Meadowridge Memorial Park
Location Maryland
18. Funeral director Burgee Funeral Home
Address 3631 Falls Road
19. 9/23/46 (Date received by registrar) 19..... A. W. Deems Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21- 1946, at 12:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15- 1945 to 9/21 1946 and that I last saw h.. alive on 9/21 1946

Immediate cause of death	DURATION
Carcinoma, primary in kidney,	1 yr.
Due to (a) General Hydronephroma	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Nephrectomy
Date of op. May 20/46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wilmer E. Ennis M.D.
M. D. or other
Address Cockeysville Md. Date signed 9/21/46.

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County 08842

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1201 N. Curley St.,
(If rural, give LOCATION)

2.(a) If veteran, name war WW II

3.(a) FULL NAME GEORGE R. STARKEY, JR. (GEORGE RICHARD STARKEY)

3.(b) Social Security Number 215-01-4330

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife X

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6/28/1911

8. AGE: Years	Months	Days	If less than one day
35	3	0	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Journalist

11. Industry or business

FATHER
12. Name George R. Starkey, Sr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden name Ellen Pope
15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/46 (month) (day) (year)
Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18. Funeral director H. Sander & Sons, Inc.
Address North Ave., and Broadway, Balto., Md.

19. 10/1 1946 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1946 at 9:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 1946, to Sept. 28 1946 and that I last saw him alive on September 28 1946

Immediate cause of death	DURATION
CEREBRAL EDEMA	
CAUSE UNDETERMINED	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation INCREASED INTRACRANIAL PRESSURE Date of op.

Autopsy results SUBSTANTIATED AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide UNDETERMINED Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Davis M.D.
Dept. Med. Univ. Balto. M.D., or other
Address [illegible] Date signed 9/29/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08843

Reg. Dist. No. 32

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mos., 21 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 2 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 122 S. Wolfe Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Stass

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 4, 1918

8. AGE: Years	Months	Days	If less than one day
28	7	28	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Receptionist

11. Industry or business:

FATHER
12. Name: Justin Stass
13. Birthplace: Poland

MOTHER
14. Maiden name: Josephine Strempek
15. Birthplace: Poland

18. Informant: Anna Stass
Address: 122 S. Wolfe St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1946 (month) (day) (year)
Cemetery or crematory: Holy Rosary Cemetery
Location: German Hill Rd., Balto., Md.

18. Funeral director: Lilly & Zeiler, Inc.
Address: 403 S. Wolfe St., Balto., Md.

19. Sept. 1, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1946 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1945, to Sept. 1, 1946 and that I last saw her alive on September 1, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	13 Years
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shoffner M.D. M.D. or other
Address: Mount Wilson, Md. Date signed: 9/1/46

Rec'd 9-4-46 Dr E E Nichols

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

#8840

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: 3318 Washington Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3318 Washington Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Howard Clinton Stauffer
3.(b) Social Security Number: 216-01-7904

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith L. Stauffer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): December 21, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	19	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Retired
FATHER 12. Name: George W. Stauffer
13. Birthplace: Maryland
MOTHER 14. Maiden name: Henrietta Cartwright
15. Birthplace: Maryland
16. Informant: Edith L. Stauffer
Address: 3318 Washington Blvd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Maryland
18. Funeral director: George L. Colvert
Address: 2101 Frederick Avenue
19. Sept 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10, 1946, at 2:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1946 to Sept. 10 1946
and that I last saw h... alive on Sept 10 1946

Immediate cause of death	DURATION
Mitral Insufficiency	7 yrs.
Due to Arteriosclerosis	7 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: / Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. B. Parran M. D.
M. D. or other
Address: Edgewater Date signed Sept 11-46


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SEP 19 1946
BUREAU
RECEIVED
SEP 19 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-B)

CERTIFICATE OF DEATH

08844 8

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Balto.

City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
5119 Rolling Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5119 Rolling Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: FREDERICK WILLIAM TEGELER, JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: Anna M. Tegeler (nee Muhly)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 14, 1892

8. AGE: Years	Months	Days	If less than one day
54	5	23	..... hrs. ..... min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual occupation: Secretary & Treasurer

11. Industry or business: P. M. Womble Lumber Co.

FATHER
12. Name: Frederick Wm. Tegeler, Sr.
13. Birthplace: Germany

MOTHER
14. Maiden name: Augusta M. Schmidt
15. Birthplace: Philadelphia

16. Informant: Mrs. Frederick Wm. Tegeler, Jr.
Address: 5119 Rolling Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/46 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 9/9 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7, 1946 at 11:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2- 1946 to Sept. 7 1946 and that I last saw h.. alive on Sept 6 1946

Immediate cause of death	DURATION
Acute Cardiac Failure	Immediate
Due to Emphysema -	Years
Due to Bronchiectasis -	Years -
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Charles J. Townsend, M.D.
M. D. or other

Address: 910 W. Lombard St Date signed: 9 Sept. 46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d)

08845

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution? 43 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2749 Mosher Street,
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3.(a) FULL NAME

JOHN TEVES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Bertha Teves

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): 8-14-80

8. AGE: Years	Months	Days	If less than one day
66	1	3	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Henry L. Teves
13. Birthplace: Germany

MOTHER
14. Maiden name: Lena Schnappinger
15. Birthplace: ?

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) ✓ Date thereof: Sept. 20, 1946 (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery
Location: Baltimore, Md.

18. Funeral director: Witzke Undertaker
Address: 4101 Edmondson Ave., Baltimore, Md.

19. 9-18-46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17, 1946, at 7:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1946, to Sept. 17, 1946 and that I last saw him alive on September 17, 1946

Immediate cause of death	DURATION
Adenocarcinoma, primary in recto-sigmoid junction with metastasis to the liver	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Abdominal perineal resection of rectum with colostomy. Date of op. 8-15-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIRECTOR

Address: V. A. Ft. Howard, Md. Date signed: 9-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly, and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 08843

1. PLACE OF DEATH:
County Balto.
City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs
Hospital, Institution, or street address where death occurred:
19 Madaline Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 Madaline Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Thomas

3.(b) Social Security Number 214-18-1174

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret Thomas
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23rd 1860

8. AGE: Years	Months	Days	If less than one day
86	7	28	hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation retired bootkeeper
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Mrs. Wm Thomas
Address 19 Madaline Ave. Balto. 6 Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 24 46 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Balto Co. Md
18. Funeral director Lasnahan Funeral Home
Address 7401 Belair Rd.
19. Sept 21 1946 (Date rec'd by registrar) Mae L. Reynolds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20th 1946 at 9:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Sept 20 1946 and that I last saw h alive on Sept 20 1946

Immediate cause of death	DURATION
Carcinoma of bladder	3 months
Due to Arteriosclerosis	10 yrs
Due to myocardial insufficiency	3 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward A Benson M. D. or other
Address 100 Dreda Date signed 9/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

CERTIFICATE OF DEATH

08847

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 W. Franklin St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: FREDERICK W. TREUDE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-10-1887

8. AGE: Years	Months	Days	If less than one day
58	8	24	hrs. min.

9. Birthplace: Philadelphia, Pa
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER — 12. Name: Unknown
13. Birthplace: "

MOTHER — 14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-10-46 (month) (day) (year)
Cemetery or crematory: Philadelphia Nat'l Cemetery
Location: Philadelphia, Pa.

18. Funeral director: Oder Funeral Home Inc.
Address: 4644 York Rd., Balto., Md.

19. 9/6/46 (Date rec'd by registrar) 19

G. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4, 1946, at 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2, 1946, to September 4, 1946
and that I last saw him alive on September 4, 1946

Immediate cause of death: HEART DISEASE — DURATION: Unknown
RHEUMATIC, WITH MITRAL STENOSIS

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.: stenosis

Autopsy results: Rheumatic valvulitis, mitral

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M Cullison
ROBERT M. CULLISON, M.D. CLIN. DIR.
M. D. or other
Address: Fort Howard, Maryland Date signed: 9/5/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08848

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
6731 Windsor Mill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6731 Windsor Mill Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN C. UHLER

3.(b) Social Security Number: 215-03-7494

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Emma Uhler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 19, 1875

8. AGE: Years	Months	Days	If less than one day
71	8	9	hrs. min.

9. Birthplace: Baltimore Co., Md.
(Town, county, and state)
10. Usual occupation: Equipment Man
11. Industry or business: Western Union

FATHER
12. Name: John H. Uhler
13. Birthplace: Baltimore Co. Md.

MOTHER
14. Maiden name: Emma Fitch
15. Birthplace: Baltimore Md.

16. Informant: Mr. Henry Uhler
Address: 3233 Phelps Lane 29

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/1/46 (month) (day) (year)
Cemetery or crematory: Oakland M. E. Cem.
Location: Carroll Co., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 9 | 30 | 46 (Date rec'd by registrar) F. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28, 1946, at 1:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 1946, to Sept 28 1946 and that I last saw h... alive on Sept 27 1946

Immediate cause of death	DURATION
Tuberculosis with a cerebral Vase accident	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos. F. Ogden M. D. or other
Address: 4509 Liberty Heights Ave. Date signed: 9-29-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Reed V.S.
9/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08849

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Balto Co Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

7603 Poplar Ave.

How long in hospital or institution? Colgate

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Dundalk R-5

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7603 Poplar Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen Lucinda Walsh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife John J. Walsh

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) 8-30-1860

8. AGE: Years 86 | Months ✓ | Days ✓ | If less than one day ... hrs. ... min.

9. Birthplace Carroll County (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housework

FATHER 12. Name Jacob N. Hoover

FATHER 13. Birthplace Carroll County

MOTHER 14. Maiden name ✓

MOTHER 15. Birthplace

16. Informant Brother

Address Westminster Carroll County

17. Wesley Cem (Burial, cremation, or removal. Which?) Date thereof Oct 3 1946 (month) (day) (year)

Burial Wesley Cemetery

Cemetery or crematory

Location near Hampstead

18. Funeral director J. E. Myers Jr.

Address Westminster Md

19. Oct 1 1946 (Date rec'd by registrar) J. G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1946 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to Sept 30 1946

and that I last saw her alive on Sept 30 1946

	DURATION
Immediate cause of death Pulmonary edema	
Due to Cardiac Failure	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. A. Jacobs MD M. D. or other

Address 617 North St Rd Date signed 9/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

08850

CERTIFICATE OF DEATH

Reg. Diat. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Hood's Nursing Home, 5315 Edmondson Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County ~~Baltimore~~
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 714 N. Payson St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cora Belle Watt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife Late James Watt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1861.

8. AGE: Years	Months	Days	If less than one day
85	3	21	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name James McCurdy
13. Birthplace U.S.A.

MOTHER
14. Maiden name Amanda J. Sevier
15. Birthplace Unknown

16. Informant Mrs. Blanche Crawley (daughter)
Address 714 N. Payson St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 24/46. (month) (day) (year)
Cemetery or crematory Woodlawn
Location Woodlawn, Md.
18. Funeral director Harry A. Nitzke
Address 4101 Edmondson Ave.

19. 9/23/46 (Date rec'd by registrar) 19..... A. W. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1946, at 9 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 2 1946 to Sept 21 1946
and that I last saw h.. alive on Sept 21 1946

Immediate cause of death	DURATION
Cerebral Arterio Sclerosis	2 Yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jane Stowell M. D. or other
Address 915 Frederick Date signed 9-23-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49a)

CERTIFICATE OF DEATH

08851

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Baltimore
City or town 2305 Monumental Ave (Lansdowne)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2305 Monumental Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Kallek Weibe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ late August Weibe
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17, 1856

8. AGE: Years	Months	Days	If less than one day
90	3	26	..... hrs. ..... min.

9. Birthplace Austria Hungary (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Stephen Kallek
13. Birthplace Austria-Hungary

MOTHER
14. Maiden name Barbara Person
15. Birthplace Austria-Hungary

16. Informant Mrs. Rose Kunzelman
Address 2919 Bauerwood Ave (Baltimore)

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16 1946 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location 4330 Belair Rd
18. Funeral director Harry F. Witzke
Address 4101 Edmondson Ave
19. Sept 14 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1946 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30. 1945 to Sept 12 1946; and that I last saw h.e.r alive on Sept 12 1946

Immediate cause of death	DURATION
Cystic Carcinoma of Ovary	Sept 1945 ?
Due to	
Due to	
Other conditions Senility	?

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Carl P. Rostkier M. D. or other
Address 131 N Lombard St Date signed 9/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

08852

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred: 1916 Lyman oak ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto.
City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)
Street No. 1910 Lyman Oak Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME GASENA T. WEIK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femak	White	married.

6.(b) Name of husband or wife Francis J. Weik
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 12, 1899

8. AGE: Years	Months	Days	If less than one day
47	6	24	hrs. min.

9. Birthplace New York (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business at Home.
FATHER 12. Name William Schaeffler
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Jacabena Jacabson
15. Birthplace unknown
16. Informant Mrs. Francis J. Weik.
Address 1910 Lyman Oak Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/9/46 (month) (day) (year)
Cemetery or crematory Lorraine.
Location Balto. Co.
18. Funeral director L. Vernon Lemmon
Address 4611 Park Heights Ave. - Balto.
19. 9-9 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1946 19 at 12-30P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
a Coronary Occlusion	
Due to	
Due to Cardio Muscular disease	
Other conditions sudden death	
(Include pregnancy within 3 months of death) Inquiry	

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dept. Med. Exam. Balto. Co. M. D. or other
Address 1010 Leeds Ave Date signed 9-7-46

08853

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Ritters Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Edward Whitcomb

3.(b) Social Security Number: 215-07-8914

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace Whitcomb
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1898

8. AGE: Years	Months	Days	If less than one day
48	2	1	hrs. min.

9. Birthplace: Balto.Co. (Town, county, and state)
10. Usual occupation: Bus driver for Baltimore Transit Co.
11. Industry or business:

FATHER
12. Name: Richard Whitcomb
13. Birthplace: Balto.Co.

MOTHER
14. Maiden name: Clara V.Ensor
15. Birthplace: Md.

16. Informant: Grace Whitcomb
Address: Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16, 1946 (month) (day) (year)
Cemetery or crematory: St.Thomas
Location: Balto.Co.

18. Funeral director: J.F.Eline & Sons
Address: Reisterstown, Md.

19. Sep 16 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1946, at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13, 1946, to Sept 13, 1946 and that I last saw him alive on Sept 13, 1946

Immediate cause of death	DURATION
Angina Pectoris	1 wk
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) None
Means of injury Injured at work?

23. SIGNATURE: H. D. Eagles, M. D. Med Exam (M. D. or other)
Address: Reisterstown, Md. Date signed: 9-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08854 Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County BALTO. CO
City or town PARKVILLE MD
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 2911 Taylor Rd
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 41 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County BALTO
City or town PARKVILLE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2911 Taylor Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME JANE MARGARET Wildberger

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a)Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife August M. WILDBERGER
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JAN 23 1877.

8. AGE: Years 69 | Months 8 | Days 3 | If less than one day ____ hrs. ____ min.

9. Birthplace Kingsville, MD. (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name EVERHART/NURSING

13. Birthplace GERMANY.

MOTHER 14. Maiden name ~~Jane~~ mary Rogers

15. Birthplace Kingsville, Md.

16. Informant IRENE Wildberger
Address 2911. Taylor Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 30 46 (month) (day) (year)
Cemetery or crematory St. Johns Lutheran
Location Balto Co. Md.

18. Funeral director Loabaker Funeral Home
Address 7401 Belair Rd.

19. 9/28/46 (Date rec'd by registrar) A. M. Baron Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26-1946, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1940, to Sep. 26 1946, and that I last saw him alive on 2:48 P.M. 9/26/46

DURATION

Immediate cause of death Myocarditis

Due to Tuberculosis Pulmonary

Due to DIABETES

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Victor Edwards MD
M. D. or other
Address 321 Delaware Date signed 9/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

08855

2411 N. Charles St., Baltimore (83-G)

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 3 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore Co.
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward E. Williams

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Emma Newman Williams
6.(c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): Unknown (Approx. age)

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	Unknown			

9. Birthplace: Hagerstown, Maryland (Town, county, and state)
10. Usual occupation: Cleaner
11. Industry or business

FATHER
12. Name: Not available
13. Birthplace: " "

MOTHER
14. Maiden name: " "
15. Birthplace: " "

16. Informant: Mrs. Sofia Tindall
Address: 1621 Madison Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: 1206 Etting Ave., Balto., Md.

18. Funeral director: George T.A. Gibson, Sr.
Address: 1735 Druid Hill Ave., Balto., Md.

19. Sept. 1, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1 1946, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30, 1946, to Septem. 1, 1946 and that I last saw him alive on September 1, 1946

Immediate cause of death	DURATION
Cerebral Embolus	3 days
Due to	
Due to	
Other conditions: Myocardial Insufficiency; Edema of the lungs. (Include pregnancy within 3 months of death)	Unknown

Major findings of operations: No operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 9/1/46

Rec'd - 9-4-46 Dr E E Nichols

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

08856

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs ~~Church Lane~~
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Nancy Belle Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: John C Wilson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 9 1865

8. AGE: Years	Months	Days	If less than one day
80	11	4	hrs. min.

9. Birthplace: Balto Co, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Lovelas Martin
13. Birthplace: Carroll Co, Md.
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: John A Wilson
Address: Texas Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16, 1946 (month) (day) (year)
Cemetery or crematory: Pine Grove Cemetery
Location: Raynolds, Balto. Co. Md
18. Funeral director: Labadon M Brooks
Address: Sparks, md.
19. 9-13 46 (Date rec'd by registrar) 19 Walter C. Emsor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1946 at 2 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Sept 13 1946
and that I last saw h. alive on Sept 12 1946.

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Myocarditis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Holmes C. Emsor M.D. M. D. or other
Address: Cockeysville Md. Date signed 9/13/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08857

Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The nearest age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS AR 3-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1419 W. Lexington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Frank Wonneman

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ida McKinsey

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): September 7, 1898

8. AGE:	Years	Months	Days	If less than one day
	48	6	19	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: guard

11. Industry or business: Bethleham Fairfield

FATHER 12. Name: Henry Wonneman

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Rose Dauber

MOTHER 15. Birthplace: Germany

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30/46 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: 3901 Old Frederick Rd.

18. Funeral director: Henry H. Withe

Address: 4101 Edmondson Ave

19. 9/30 19 46 (Signature of registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 19 46, at 9 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 19 46 to September 26 19 46 and that I last saw h...im alive on September 26 19 46

Immediate cause of death	DURATION
Acute myocarditis	3-4 days
Due to: Chronic alcoholism	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D. or other

Address: Catonsville 28, Md. Date signed 9/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

CERTIFICATE OF DEATH

08858

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 7 months, 24 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 1 year, 7 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Dundalk 22 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2702 W. Woodville Rd. (If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Paul Wright

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: Mrs. Lucretia Wright

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): February 11, 1911

8. AGE:	Years	Months	Days	If less than one day
	35	6	25	hrs. min.

9. Birthplace: Lewisburg, West Virginia (Town, county, and state)

10. Usual occupation: truck driver

11. Industry or business: trucking company

FATHER

12. Name: Joe Osborn Wright

13. Birthplace: Virginia

MOTHER

14. Maiden name: Nettie Green

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Baltimore 28, Md. (Catonsville)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9/46 (month) (day) (year)

Cemetery or crematory: Lewisburg W Va

Location: Lewisburg W Va

18. Funeral director: Chas S MacNabb

Address: Catonsville Md

19. 9-6 1946 (Date received by registrar) Harry S. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1946, at 6 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1945, to September 5 1946 and that I last saw him alive on September 5 1946

Immediate cause of death	DURATION
Chronic luetic myocarditis	Indef.
Due to General Paresis	Indef.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk

Isadore Tuerk M. D. or other

Address: Catonsville 28, Md. Date signed: 9/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0885?

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: BALTIMORE

City or town: TOWSON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 ½ Yrs

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or institution? 2 ½ Yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: North Carolina County: Catawba

City or town: Hickory

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 404 Sixth St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Willard, Mrs. Cecil Young

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: J.J. Willard

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): August 25, 1885

8. AGE: Years 61 | Months 0 | Days 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Corinth, Miss.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Robert F. Young
13. Birthplace: Miss.

MOTHER
14. Maiden name: Mary Jane Henry
15. Birthplace: Miss

16. Informant: HOSPITAL RECORDS

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 9-1946 (month) (day) (year)

Cemetery or crematory: Oakwood

Location: Hickory, Catawba Co, N.C.

18. Funeral director: Putnam & Gore

Address: 2224 N.Charles St

19. Sept 9 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7, 1946, at 6:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: carcinoma of bladder	18 mo.
Due to:	
Due to:	
Other conditions: Involutional melencholia	30 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: carcinoma of bladder

Date of op. July 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. M. Murdock M. D. or other

Harry M. Murdock, M.D.

Address: TOWSON, MD. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-8)

CERTIFICATE OF DEATH

Reg. Dist. No. 118860 47

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk-Turner's Sta.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Dundalk-Turney's Sta
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 V Woodland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roger Zamitech

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 52 | Months | Days | If less than one day hrs. min.

9. Birthplace (Town, county, and state) Unknown

10. Usual occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4 46 (month) (day) (year)

Cemetery or crematory Alm House

Location Texas Balto Co. Md

18. Funeral director James Burkhardt

Address 140 N Eastern Ave.

19. Sept 4 1946 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-46 19 at 10:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cancer of tongue c	
Due to Enlarged Metastases	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M D Davis M.D.
Address Dist. Med. Exam. Balto M. D. or other
Date signed 9/4/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M